Columbus

Company Tracking Number: A71000RAPPS

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness

Limited Benefit

Product Name: Payroll, Union and Non-payroll Specified Health Event Application Forms

Project Name/Number: A71000 applications/A71001RAR

Filing at a Glance

Company: American Family Life Assurance Company of Columbus

Product Name: Payroll, Union and Non-payroll SERFF Tr Num: AFLA-126789903 State: Arkansas

Specified Health Event Application Forms

TOI: H07I Individual Health - Specified Disease SERFF Status: Closed-Approved- State Tr Num: 46768

- Limited Benefit Closed

Sub-TOI: H07I.001 Critical Illness Co Tr Num: A71000RAPPS State Status: Approved-Closed

Filing Type: Form Reviewer(s): Rosalind Minor

Author: Coppie Gates Disposition Date: 09/24/2010

Author: Connie Gates Disposition Date: 09/24/2010
Date Submitted: 09/13/2010 Disposition Status: Approved-

Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: A71000 applications Status of Filing in Domicile: Pending

Project Number: A71001RAR Date Approved in Domicile:

Requested Filing Mode: Review & Approval Domicile Status Comments: Similiar versions of

the application forms are being filed

concurrently in Nebraska.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Market Type: Individual

Group Market Size:

Group Market Type:

Filing Status Changed: 09/24/2010 Explanation for Other Group Market Type:

State Status Changed: 09/24/2010

Deemer Date: Created By: Connie Gates

Submitted By: Connie Gates Corresponding Filing Tracking Number:

Filing Description:

A filing description letter is attached under the supporting documentation tab.

Company and Contact

Columbus

Company Tracking Number: A71000RAPPS

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness

Limited Benefit

Product Name: Payroll, Union and Non-payroll Specified Health Event Application Forms

Project Name/Number: A71000 applications/A71001RAR

Filing Contact Information

Connie Gates, Policy Analyst cgates@aflac.com
1932 Wynnton Road 706-596-5048 [Phone]
Columbus, GA 31999 706-660-7080 [FAX]

Filing Company Information

American Family Life Assurance Company of CoCode: 60380 State of Domicile: Nebraska

Columbus

1932 Wynnton Road Group Code: Company Type: Life and Health

Columbus, GA 31999 Group Name: State ID Number:

(706) 323-3431 ext. [Phone] FEIN Number: 58-0663085

Filing Fees

Fee Required? Yes
Fee Amount: \$0.00
Retaliatory? No

Fee Explanation: \$50 per form

5 forms x 50 = \$250

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

American Family Life Assurance Company of \$250.00 09/13/2010 39457658

Columbus

Columbus

Company Tracking Number: A71000RAPPS

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness

Limited Benefit

Product Name: Payroll, Union and Non-payroll Specified Health Event Application Forms

Project Name/Number: A71000 applications/A71001RAR

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	09/24/2010	09/24/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Payroll/Union Application	Connie Gates	09/24/2010	09/24/2010
Form	Payroll/Union Application	Connie Gates	09/24/2010	09/24/2010
Form	Non-payroll Application	Connie Gates	09/24/2010	09/24/2010
Form	Non-payroll Application	Connie Gates	09/24/2010	09/24/2010
Form	Request for Change/Application for	Connie Gates	09/24/2010	09/24/2010
	Reinstatement and/or Additions			

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Attachments to Form Schedule	Note To Filer	Rosalind Minor	09/23/2010	0 09/23/2010

 SERFF Tracking Number:
 AFLA-126789903
 State:
 Arkansas

 Filing Company:
 American Family Life Assurance Company of
 State Tracking Number:
 46768

Columbus

Company Tracking Number: A71000RAPPS

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness

Limited Benefit

Product Name: Payroll, Union and Non-payroll Specified Health Event Application Forms

Project Name/Number: A71000 applications/A71001RAR

Disposition

Disposition Date: 09/24/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Columbus

Company Tracking Number: A71000RAPPS

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness

Limited Benefit

Product Name: Payroll, Union and Non-payroll Specified Health Event Application Forms

Project Name/Number: A71000 applications/A71001RAR

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form (revised)	Payroll/Union Application	Approved-Closed	Yes
Form	Payroll/Union Application	Replaced	Yes
Form (revised)	Payroll/Union Application	Approved-Closed	Yes
Form	Payroll/Union Application	Replaced	Yes
Form (revised)	Non-payroll Application	Approved-Closed	Yes
Form	Non-payroll Application	Replaced	Yes
Form (revised)	Non-payroll Application	Approved-Closed	Yes
Form	Non-payroll Application	Replaced	Yes
Form (revised)	Request for Change/Application for	Approved-Closed	Yes
	Reinstatement and/or Additions		
Form	Request for Change/Application for Reinstatement and/or Additions	Replaced	Yes

 SERFF Tracking Number:
 AFLA-126789903
 State:
 Arkansas

 Filing Company:
 American Family Life Assurance Company of
 State Tracking Number:
 46768

Columbus

Company Tracking Number: A71000RAPPS

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness

Limited Benefit

Product Name: Payroll, Union and Non-payroll Specified Health Event Application Forms

Project Name/Number: A71000 applications/A71001RAR

Amendment Letter

Submitted Date: 09/24/2010

Comments:

Forms are attached to the forms schedule tab.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form	Form	Form	Action	Form	Previous	Replaced	Readability	Attachments
Number	Туре	Name		Action Other	Filing #	Form #	Score	
A71001RAR	R Application/l nrollment Form	EPayroll/Unio n Applicatior			unknown	A71001ARR 1 & A71001AAR R1		A71001RAR.p df
A71001L1A R	Application/Inrollment Form	EPayroll/Unio n Applicatior					70.904	A71001L1AR. pdf
A71002RAR	Application/Inrollment Form	ENon-payroll Application	Revised		unknown	A71002AAR R1	71.041	A71002RAR.p df
A71002RcA R	Application/Inrollment Form	ENon-payroll Application	Revised		unknown	A71002ARR 1	70.120	A71002RcAR. pdf
A71003RAR	R Application/l nrollment Form	ERequest for Change/App ication for Reinstatement and/or Additions	ıl		unknown	A71003ARR 1	72.189	A71003RAR.p

SERFF Tracking Number: AFLA-126789903 State: Arkansas

Filing Company: American Family Life Assurance Company of State T

State Tracking Number:

46768

Columbus

Company Tracking Number: A71000RAPPS

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness

Limited Benefit

Product Name: Payroll, Union and Non-payroll Specified Health Event Application Forms

Project Name/Number: A71000 applications/A71001RAR

Note To Filer

Created By:

Rosalind Minor on 09/23/2010 01:41 PM

Last Edited By:

Rosalind Minor

Submitted On:

09/24/2010 12:03 PM

Subject:

Attachments to Form Schedule

Comments:

Connie - There are no attachments to the Form Schedule Tab. It looks like you are attempting to submit replacement forms, but there are no forms attached.

Columbus

Company Tracking Number: A71000RAPPS

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness

Limited Benefit

Product Name: Payroll, Union and Non-payroll Specified Health Event Application Forms

Project Name/Number: A71000 applications/A71001RAR

Form Schedule

Lead Form Number: A71001RAR

Schedule Item Status	Form Number	Form Type	e Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 09/24/2010	R		n/Payroll/Union Application	Revised	Replaced Form #: A71001ARR1 & A71001AARR1 Previous Filing #: unknown	57.171	A71001RAR. pdf
Approved- Closed 09/24/2010	R		/Payroll/Union Application	Initial		70.904	A71001L1AR. pdf
Approved- Closed 09/24/2010	R		n/Non-payroll Application	Revised	Replaced Form #: A71002AARR1 Previous Filing #: unknown	71.041	A71002RAR. pdf
Approved- Closed 09/24/2010	AR		n/Non-payroll Application	Revised	Replaced Form #: A71002ARR1 Previous Filing #: unknown	70.120	A71002RcAR. pdf
Approved- Closed 09/24/2010	R		/Request for Change/Application for Reinstatement and/or Additions	Revised	Replaced Form #: A71003ARR1 Previous Filing #: unknown	72.189	A71003RAR. pdf



SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY (A71000 Series) Supplemental Health Insurance Coverage

[□Payroll	
□Union]	
☐ New ¯	
Conversion	

Application to: American Family Life Assurance Company of Columbus (Aflac) [Worldwide Headquarters • Columbus, Georgia 31999]

☐ Conversion
Policy Number:

Please Print in Black Ink – To Be C	ompleted by Pro	pposed Insured[/Employ	ree]
Proposed Insured's[/Employee's] Name			
Last		First	MI
DOB Sex	SSN	-	-
DOB Sex			(Optional)
Address			
Street or Post Office Box		Αŗ	ot. No.
City	State	ZIP	
Primary Telephone ()	Secondary	Telephone ()	
E-Mail Address (optional)			
Are you applying for Dependent Child(ren) coverage? If yes, Dependent Children must be under age 26 at the ti		ı.	
Write spouse's name below if you are applying for Tw you have no spouse or your spouse is not to be cove			use Only coverage; if
Spouse's Name		DOB	Sex
Spouse's Name Last First	MI	DOB Month/Day/Year	
[Payroll] Account Name		[Payroll] Account No.	
			(Optional)
[Name of Employer]		
Is this insurance intended to replace any other health insulf yes, please read and sign the Replacement Notice prov			☐ Yes ☐ No
Does anyone to be covered have any other Specified Heacoverage with Aflac?	alth Event or any	Lump Sum Critical Illness	s □ Yes □ No
If yes, this must be a conversion of that coverage. If yes Applicant's Statements and Agreements concerning conv Policy Number:		cy number and see	
Does anyone to be covered have any Hospital Intensive (Care coverage wi	th Aflac?	☐ Yes ☐ No
If yes, you may not apply for Plan 2 (Policy Series A71200 Intensive Care policy is terminated. If desired, please c application and be aware that you cannot have Plan 2 of Hospital Intensive Care policy with Aflac.	complete the Sup	plemental Notification se	

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:		□ Named Insured/ Spouse Only	☐ One-Parent F	amily	arent Family
□ Plan 2: Critical A71200) □ First-Occurrence Options: □ No □ Primary Specific	Care and Recovered Building Benefit For ider Dewrided Health Event Re	Only (Policy Series A712 Very with Hospital Intention Rider (Rider Series A7103 er □Retain current rid covery Rider (Rider Serie er □Retain current rid	sive Care Unit Be 50) (\$500) ler es A71051)	enefits (Policy Series	□ Pre-Tax or □ After-Tax
List Bill PLEASE NOTE:	If B/D, ACH, C/C	e: 11 Weekly 1 14-Day Biweekly 11 28-Day Biweekly 5, Direct, or List Bill bi parterly, Semiannual, or	illing method is c		al
Employee No		Dept. No		Assoc./Agent's No	
Billable Premium \$		Premium Collecte	ed \$	Sit. Code	1
	PLEASE C	OMPLETE THE FOLLO	WING FLIGIBILITY	QUESTIONS	
front of this	urrently employed s application? are not eligible for	and actively working at y	our job with the er	nployer listed on the	□ Yes □ No
	PLEASE COI	MPLETE THE FOLLOWI	NG UNDERWRITIN	IG QUESTIONS	
a member Heart Attao Stroke or T	of the medical prof ck ransient Ischemic	re you or anyone to be co ession at a health facility Attack (TIA) er than stones or acute in	for any of the follow		□ Yes □ No
	•	e you or anyone to be co		advised by a member	□ Yes □ No
Coronary a	n transplant artery bypass surge y or stent placeme				
If either u	nderwriting Quest	ion 1 or 2 directly above	e is answered yes	, was it the:	
☐ Propose	ed Insured[/Employ	/ee]? ☐ Spouse? ☐ (Child? If child, p	please list the name of	the child(ren)
Any person(s	a policy will	will not be covered un not be issued; therefor there other children to l	re do not submit th		[/Employee],

IF YOU ARE APPLYING FOR PLAN 1 ONLY, QUESTIONS 3 THROUGH 10 ARE NOT REQUIRED TO BE ANSWERED. PLEASE ONLY COMPLETE QUESTIONS 3 THROUGH 10 IF YOU ARE APPLYING FOR PLAN 2, POLICY SERIES A71200.

3.	Are you or anyone to be covered the mother or father of a child currently conceived but as yet unborn?	□ Yes □ No
	PLEASE NOTE: Children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life.	
	PLEASE INITIAL: Proposed Insured/Employee	
4.	Are you or anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician?	□ Yes □ No
5.	Have you or anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease, or sickle cell anemia or cystic fibrosis?	□ Yes □ No
6.	Have you or anyone to be covered ever been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)?	□ Yes □ No
7.	Have you or anyone to be covered ever been diagnosed with or treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea?	□ Yes □ No
8.	In the last five years, have you or anyone to be covered been diagnosed with or treated by a member of the medical profession for angina (heart related chest pains), congestive heart failure, or diabetes requiring the use of insulin?	□ Yes □ No
9.	In the last five years, have you or anyone to be covered had or been advised by a member of the medical profession to have any of the following: heart valve surgery, surgery for congenital heart defects, or coronary atherectomy?	□ Yes □ No
10.	In the last 12 months, have you or anyone to be covered received treatment for more than 24 hours in a Hospital Intensive Care Unit (not including treatment as a result of an accident)?	□ Yes □ No
	If any one of Questions 4 through 10 is answered yes, was it the:	
	☐ Proposed Insured[/Employee]? ☐ Spouse? ☐ Child? If child, please list the name of the content	he child(ren).
	Any person(s) indicated above will not be covered under this policy. If the Proposed Insure a policy will not be issued; therefore, do not submit this application.	ed[/Employee],
	If a Child, are there other children to be covered? □Yes □ No	

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The Intensive Care Benefits A, B, and J of the Plan 2 policy (Series A71200) reduce to half at age 70.
- I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.

- I understand that Dependent Children, if any, must be under age 26 at the time of application. Once covered, Dependent Children will continue to be covered until their 26th birthday. I acknowledge receipt of, if applicable: □ Replacement Notice Outline of Coverage ☐ Guide To Health Insurance for People with Medicare If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy; (2) The "Time Limit on Certain Defenses" provision in your policy will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The "Pre-existing Condition Limitations" in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the "Pre-existing Condition Limitations" in the new policy will run from the new policy's Effective Date. I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy. I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable. If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy. Proposed Insured's Initials I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy.
- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

SUPPLEMENTAL NOTIFICATION COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC HOSPITAL INTENSIVE CARE COVERAGE.
I,, am applying for Aflac's Specified Health Event Policy (Plan 2), which contains hospital intensive care benefits. I currently have hospital intensive care benefits under Aflac's Hospital Intensive Care Policy Number I understand that I must cancel existing Aflac Hospital Intensive Care coverage to purchase this Specified Health Event policy.
□ Please cancel my Hospital Intensive Care Policy Number I understand that I will be terminating benefits provided for in my current Hospital Intensive Care policy that may not be provided for in the new Specified Health Event policy.
 I would prefer to receive an electronic copy of my policy instead of paper. ☐ Yes ☐ No
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Signed and Dated at on On Date
Proposed Insured's[/Employee's] Signature
[I certify that I personally saw the Proposed Insured[/Employee] when the application was written, and each question was asked of the Proposed Insured[/Employee] and answered as recorded. All answers above are correct to the best of my knowledge.]
[Associate's/Agent's Signature Date Licensed Resident Associate/Agent]

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),
CLIENT SERVICES AND ADMINISTRATION,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.]

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:

ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION

1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR

TOLL-FREE 1-800-852-5494.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- * hospitalization
- * physician services
- * hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- * Check the coverage in **all** health insurance policies you already have.
- * For more information about Medicare and Medicare Supplement insurance, review the Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare, available from the insurance company.
- * For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).



SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY (A71100 Series)

Supplemental Health Insurance Coverage

Application to: American Family Life Assurance Company of Columbus (Aflac) [Worldwide Headquarters • Columbus, Georgia 31999]

Please Print in Black Ink – To Be Completed by Proposed Insured[/Employee]					
Proposed Insured's[/Employee's] Name					
	Last		First	MI	
DOB	Sex	SSN	-	-	
DOB Month/Day/Year				(Optional)	
Address					
Street or Post Office	Box		A	Apt. No.	
City	Sta	te	ZIP		
Primary Telephone ()	:	Secondary Teler	ohone ()		
E-Mail Address (optional)			_		
Are you applying for Dependent Child If yes, Dependent Children must be u					
Write spouse's name below if you a you have no spouse or your spous				ouse Only coverage; if	
Spouse's Name		DC)B	Sex	
Spouse's NameLast				Sex	
[Payroll] Account Name		[Pav	roll1 Account No.		
[Name of Employer				(Optional)	
Is this insurance intended to replace any other health insurance now in force? If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.					
Does anyone to be covered have any coverage with Aflac?	other Specified Health E	vent or any Lum	p Sum Critical Illnes	ss Yes No	
If yes, this must be a conversion of that coverage. If yes, give current policy number and see Applicant's Statements and Agreements concerning conversions.					
Policy Number:					
ТО	BE COMPLETED BY AF	LAC ASSOCIA	ΓΕ/AGENT		
Check Coverage	□ Named Insured/ Spouse Only	☐ One-Parer	nt Family	Two-Parent Family	
□ Plan 1: Critical Care and Recovery□ First-Occurrence Building Benefit I				☐ Pre-Tax	
Options: No rider New rid	ler Retain current rid	er		or or	
Primary Specified Health Event Re				☐ After-Tax	

	ling Method: Payroll Deduction Bank Draft (B/D, ACH) Credit Card (C/C) Direct List Bill	Mode: ☐ 01 Weekly ☐ 01 14-Day Biweekly ☐ 01 28-Day Biweekly		hly	☐ 06 Sem ☐ 12 Annu	
		H, C/C, Direct, or List Bill nly, Quarterly, Semiannual, o		d is checke	ed, only the fo	llowing modes of
Emp	ployee No	Dept. No		Asso	oc./Agent's No.	
Billa	able Premium \$	Premium Collec	cted \$	Sit. (Code]
	PLE	ASE COMPLETE THE FOLL	OWING ELIGIE	SILITY QUES	STIONS	
1.	. Are you currently emp front of this application If No, you are not eligit		t your job with	the employe	er listed on the	□ Yes □ No
	PLEAS	SE COMPLETE THE FOLLOW	WING UNDERV	VRITING QU	IESTIONS	
1.		ars, have you or anyone to be edical profession at a health fa				□ Yes □ No
	Heart Attack Stroke or Transient Isc Impaired kidney function	chemic Attack (TIA) on (other than stones or acute	e infection)			
2.		ears, have you or anyone to I profession of the need to have			advised by a	☐ Yes ☐ No
	Major organ transplant Coronary artery bypas Angioplasty or stent pl	s surgery				
	If either underwriting	Question 1 or 2 directly abo	ove is answere	d yes, was	it the:	
	☐ Proposed Insured[/Employee]? ☐ Spouse? ☐ Child? If child, please list the name of the child(ren)					
		d above will not be covered licy will not be issued; there				ed[/Employee],
	If a C	Child, are there other childre	en to be covere	d?	□Yes □ No	
		AND AGREEMENTS: ective Date of the policy will tis not the date I signed this a		recorded in	the Policy Sch	nedule by Aflac
•	I understand that the poli Effective Date of the policy	cy I am applying for will not	t cover any per	rson who ha	as attained age	71 before the
	treatment was recommend	e is not provided for Specified led or received within the six- occurs more than 30 days aft	month period be	efore the Effe	ective Date of c	
	Dependent Children will co	ent Children, if any, must be ontinue to be covered until the			of application.	Once covered,
•	I acknowledge receipt of, if ☐ Replacement Notice ☐ Guide To Health Inst			of Coverage	e	

Form A71001L1AR 2 of 4

- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy; (2) The "Time Limit on Certain Defenses" provision in your policy will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The "Pre-existing Condition Limitations" in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the "Pre-existing Condition Limitations" in the new policy will run from the new policy's Effective Date.
- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I understand that the premium amount listed on this application represents the premium amount that my employer
 will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll
 practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on
 an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

Proposed Insured's Initials

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy.
- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

I would prefer to receive an electronic copy of my policy inst	tead of paper. □ Yes □ No
Any person who knowingly presents a false or fraudulen presents false information in an application for insurance confinement in prison.	
Signed and Dated at City and State	on Date
Proposed Insured's[/Employee's] Signature	

[I certify that I personally saw the Proposed Insured[/Employee] when the application was written, and each question was asked of the Proposed Insured[/Employee] and answered as recorded. All answers above are correct to the best of my knowledge.]

[Associate's/Agent's Signature		Date	

Licensed Resident Associate/Agent]

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),

CLIENT SERVICES AND ADMINISTRATION,

[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.

FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).

VISIT OUR WEB SITE AT AFLAC.COM.]

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:

ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION

1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR

TOLL-FREE 1-800-852-5494.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- * hospitalization
- * physician services
- * hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- Check the coverage in all health insurance policies you already have.
- * For more information about Medicare and Medicare Supplement insurance, review the Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare, available from the insurance company.
- * For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).



SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY (A71000 Series)

Supplemental Health Insurance Coverage
Application to: American Family Life Assurance Company of Columbus (Aflac)

[Worldwide Headquarters • Columbus, Georgia 31999]

□ Conversion

■ New

Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured						
Proposed Insured's Name						
	Last		First	MI		
DOB	Sex	SSN				
Month/Day/Year				(Optional)		
Address						
Street or Post	Office Box		A	Apt. No.		
City		State	ZIP			
Primary Telephone ()		Secondary	Telephone ()			
State of Birth E-	Mail Address (optional)					
Are you applying for Dependent If yes, Dependent Children mus						
Write spouse's name below i if you have no spouse or you				ouse Only coverage;		
Spouse's Name			DOB	Sex		
Spouse's Name Last	First	MI	Month/Day/Year			
Name of Employer/Association Account No						
	alaaa aa a		0	(Optional)		
Is this insurance intended to relatives, please read and sign the				□ Yes □ No e.		
Does anyone to be covered have	ve any other Specified Hea	alth Event or any	Lump Sum Critical Illnes			
coverage with Aflac? If yes, this must be a conversio	n of that coverage If ves	aive current no	licy number and see	☐ Yes ☐ No		
Applicant's Statements and Ag Policy Number:	reements concerning conv		noy named and doc			
Does anyone to be covered has	ve any Hospital Intensive (Care coverage v	vith Aflac?	☐ Yes ☐ No		
If yes, you may not apply for Pl						
Intensive Care policy is termina application and be aware that y						
Hospital Intensive Care policy		ine opeomed rie	and Event policy without	canceling your existing		
TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT						
Check Coverage [☐ Individ		d/ ☐ One-	Parent Family	☐ Two-Parent		
Desired:	Spouse Only	171100		Family		
☐ Plan 2: Critical Care and	□ Plan 1: Critical Care and Recovery Only (Policy Series A71100) □ Plan 2: Critical Care and Recovery with Hospital Intensive Care Unit Benefits (Policy Series					
A71200) First-Occurrence Building Be	enefit Rider (Rider Series /	A71050) (\$500)				
Options: ☐ No rider ☐ New rider ☐ Retain current rider						
□ Primary Specified Health Event Recovery Rider (Rider Series A71051) Options: □ No rider □ New rider □ Retain current rider						

Billing Method:		Modes:				
] [Direct		ssoc.	3/D & C/C Only)	□ 06 Semiannual□ 12 Annual	
Ass	ociate's/Agent's No.	Sit. Code	Billable Premium \$	Premium	n Collected \$	
	DI FACE COMP	LETE OUESTIONS 4 TH	IDOLIOU O IE ADDI VINO	500 DI AN 4 00		
	PLEASE COMP	LETE QUESTIONS 1 TH	IROUGH 9 IF APPLYING	FOR PLAN 1 OR	PLAN 2.	
1.	Has anyone to be cover medical profession for a		with or received treatmen	it by a member of	f the ☐ Yes ☐ No	
	cardiomyopathy (excluding surgi Any disease, di to, stroke, TIA, a Chronic obstruc Cystic fibrosis Type I diabetes Impaired kidney Kidney disease	Heart Attack, congestically corrected atrial septions or abnormality of the arterial blockage, or cerebitive pulmonary disease (Confunction or disorder (excluding stords)	the circulatory system, incloral vascular insufficiency COPD) ones or acute infection) or l	genital heart dise	ease	
2.	medical profession for owith complications to it	diabetes (1) requiring the	with or received treatmen e use of insulin within the opathy, or nephropathy, o cluding gestational)?	last five years, or	or (2)	
3.		evaluated by a member of	advised to have a Major of the medical profession of			
4.	syndrome (AIDS) by a		with or treated for acquire profession, or has anyone ?			
5.			overed received chemother cal condition, not to include			
6.			ered been prescribed or re er of the medical profession		with ☐ Yes ☐ No	
7.	medical profession in a	n emergency room or hos	overed received treatment spital for hypertension/high ge to improve blood pressu	h blood pressure		
8.	the medical profession	for chest pain, shortness	ered had or received treati s of breath, blackouts, fair ssion to have diagnostic te	nting, or dizziness	s, or	

	If any one of Questions 1 through 8 is answered yes, was it the:					
	☐ Proposed Insured? ☐ Spouse? ☐ Child? If child, please list the name of the child(ren).					
	Any person(s) indicated above will not be covered under this policy. If the Proposed Insured, a policy will not be issued; therefore, do not submit this application	· n.				
	If a Child, are there other children to be covered? □Yes □ No					
9.	Please list your height and weight: Height: ft. in. Weight: lbs.					
	Additional underwriting may be required.					
	PLEASE ONLY COMPLETE QUESTIONS 10 THROUGH 17 IF APPLYING FOR PLAN 2, POLICY SERIES A71200.					
10.	Are you or anyone to be covered the mother or father of a child currently conceived but as yet unborn?	☐ Yes ☐ No				
	PLEASE NOTE: Children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life.					
	PLEASE INITIAL:					
	Proposed Insured/Employee					
11.	Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician?	☐ Yes ☐ No				
12.	Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease?	☐ Yes ☐ No				
13.	Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea?	□ Yes □ No				
14.	In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery?	☐ Yes ☐ No				
15.	Has anyone to be covered been hospitalized three or more times in the last two years?	☐ Yes ☐ No				
16.	In the last 12 months, has anyone to be covered received treatment in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit (not including treatment as a result of an accident)?	☐ Yes ☐ No				
17.	In the last 12 months, has anyone to be covered been prescribed or taken any medication for the treatment of infertility?	□ Yes □ No				
	If any one of Questions 11 through 17 is answered yes, was it the:					
	☐ Proposed Insured? ☐ Spouse? ☐ Child? If child, please list the name of the child(ren).					
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A71002RAR.1 © 2010 Aflac All Rights Reserved Form A71002RAR 3 of 6

APPLICANT'S STATEMENTS AND AGREEMENTS:

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- I understand that Dependent Children, if any, must be under age 26 at the time of application. Once covered, Dependent Children will continue to be covered until their 26th birthday.

•	I acknowledge receipt of, if applicable:	
	☐ Replacement Notice	Outline of Coverage
	☐ Guide To Health Insurance for People with Medicare	_

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	SUPPLEMENTAL NOTIFICA	TION				
COMPLETE IF YOU ARE REPLACII						
I,	,, am applying for Aflac's Specified Health Event Policy (Plan 2), which contains hospital intensive care benefits. I currently have hospital intensive care benefits under Aflac's Hospital Intensive					
Care Policy Number	s. Tourrently have hospital inten- Lunderstand that Ln	nust cancel existing Aflac Hosp	าดรpและเกเลกรเงย ital Intensive Care			
coverage to purchase this Specified Hea	alth Event policy.					
☐ Please cancel my Hospital Intensi	ive Care Policy Number	I understa	nd that I will be			
terminating benefits provided for new Specified Health Event policy	in my current Hospital Intensive	e Care policy that may not be p	provided for in the			
I would prefer to receive an electron	nic copy of my policy instead of p	paper. □ Yes □ No				
·	1,3 3,1 3	•				
Any person who knowingly presents presents false information in an appropriate confinement in prison.						
Signed and Dated at		on				
Signed and Dated atCity	y and State	on	Date			
Proposed Insured's Signature						
[Associate's/Agent's Signature		Date				
	Licensed Resident Associate	/Agent]				

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),

CLIENT SERVICES AND ADMINISTRATION,

[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.

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- * hospice
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- * For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).



SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY (A71000 Series)

Supplemental Health Insurance Coverage
Application to: American Family Life Assurance Company of Columbus (Aflac)

[Worldwide Headquarters • Columbus, Georgia 31999]

☐ Conversion	

■ New

Policy	Number:

	Please Prir	t in Black Ink – To	Be Complete	d by Proposed I	nsured		
Proposed Insured's	Name						
	Last			First		MI	
DOB		Sex	SSN_				
Month/Day	Year					(Optional)	
Address	and an Dant Office	Вох			Λ 4	4 NI-	
					·	t. No.	
City			State	ZIP			
Primary Telephone	()		Secondar	y Telephone ()		
State of Birth	E-Mail Ad	ddress (optional)					
		(ren) coverage? nder age 26 at the til					
		are applying for Tw use is not to be cov				se Only co	/erage;
Spouse's Name				_ DOB	S	Sex	_
La	ıst	First	MI	Month/I	Day/Year		
Name of Employer/	Association			Accoun	ıt No		
1 41 1 1 1 1 1	1.17	4 1 14 1				(Optional)	N
		any other health insu acement Notice provi			applicable.		□ No
		other Specified Hea	lth Event or a	ny Lump Sum Cri	tical Illness		- N
coverage with Aflact		at coverage. If yes,	give current p	olicy number and	d see	⊔ Yes	☐ No
		nts concerning conve		_			
Does anyone to be	covered have any	Hospital Intensive C	are coverage	with Aflac?		☐ Yes	□ No
		Policy Series A71200			atian aaatian		of this
	aware that you car	desired, please con nnot have Plan 2 of t					
1105pital Intensive C					· -		
Ohaali Carrana		BE COMPLETED E			11	☐ Two-Pa	
Check Coverage Desired:	□ Individual	□ Named Insured Spouse Only		e-Parent Family		Two-Pa Family	arent
☐ Plan 1: Critical C		Only (Policy Series					
Plan 2: Critical A71200)	Care and Recov	ery with Hospital	Intensive Car	e Unit Benefits	(Policy Ser	ies	
	•	Rider (Rider Series A	, , ,)			
-		er □Retain currer covery Rider (Rider		1)			
		or Detain currer		,			

Billin	g Method:		Modes:	
	rect ank Draft (B/D, ACH) st Bill	□ Emp. Nonpayroll/Assoc.□ Credit Card (C/C)	☐ 01 Monthly (B/D & C/C Only)☐ 03 Quarterly	☐ 06 Semiannual☐ 12 Annual
Asso	ciate's/Agent's No	Sit. Code	Billable Premium \$	Premium Collected \$ _
	PLEASE COMPL	FTE QUESTIONS 1 THROUGH	H 9 IF APPLYING FOR PLAN 1 O	R PI AN 2
1.		ed ever been diagnosed with or	received treatment by a member of	
	cardiomyopathy, (excluding surgic Any disease, dis to, stroke, TIA, ar Chronic obstructi Cystic fibrosis Type I diabetes Impaired kidney Kidney disease of	Heart Attack, congestive hear ally corrected atrial septal defect order or abnormality of the circulaterial blockage, or cerebral vastive pulmonary disease (COPD) function or disorder (excluding stones or disorder (excluding hepatitis A)	ulatory system, including, but not li	sease
2.	medical profession for di with complications to in-	iabetes (1) requiring the use of	received treatment by a member of insulin within the last five years, or nephropathy, or (3) with contigestational)?	or (2)
3.		valuated by a member of the m	to have a Major Organ Transplanedical profession of the need to have	
4.		nember of the medical profession	treated for acquired immune defic on, or has anyone to be covered to	
5.			received chemotherapy treatment lition, not to include hormonal treat	
6.		s, has anyone to be covered bei	en prescribed or received treatmen medical profession?	nt with ☐ Yes ☐ No
7.	medical profession in an	emergency room or hospital for	received treatment by a member or by hypertension/high blood pressure prove blood pressure readings?	
8.	the medical profession for	or chest pain, shortness of bre	nd or received treatment by a member ath, blackouts, fainting, or dizzines have diagnostic tests to evaluate	ss, or

	If any one of Questions 1 through 8 is answered yes, was it the:	
	☐ Proposed Insured? ☐ Spouse? ☐ Child? If child, please list the name of the child(ren).	
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	If a Child, are there other children to be covered? □Yes □ No	
9.	Please list your height and weight: Height: ft. in. Weight: lbs.	
	Additional underwriting may be required.	
	PLEASE ONLY COMPLETE QUESTIONS 10 THROUGH 17 IF APPLYING FOR PLAN 2, POLICY SERIES A71200.	
10.	Are you or anyone to be covered the mother or father of a child currently conceived but as yet unborn?	☐ Yes ☐ No
	PLEASE NOTE: Children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life.	
	PLEASE INITIAL: Proposed Insured/Employee	
11.	Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician?	☐ Yes ☐ No
12.	Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease?	□ Yes □ No
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14.	In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery?	☐ Yes ☐ No
15.	Has anyone to be covered been hospitalized three or more times in the last two years?	☐ Yes ☐ No
16.	In the last 12 months, has anyone to be covered received treatment in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit (not including treatment as a result of an accident)?	☐ Yes ☐ No
17.	In the last 12 months, has anyone to be covered been prescribed or taken any medication for the treatment of infertility?	□ Yes □ No
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	☐ Guide To Health Insurance for People with Medicare	_

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- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

Proposed Insured's Initials
I have reviewed the statements and answers I have provided on this application. I understand that this policy is
to be issued based upon these statements and answers, and any other pertinent information Aflac may require

- to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy.
- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

SUPPLEMEN	TAL NOTIFICATION
COMPLETE IF YOU ARE REPLACING/TERMINATING	EXISTING AFLAC HOSPITAL INTENSIVE CARE COVERAGE.
I. am apr	olving for Aflac's Specified Health Event Policy (Plan 2), which
contains hospital intensive care benefits. I currently have	olying for Aflac's Specified Health Event Policy (Plan 2), which hospital intensive care benefits under Aflac's Hospital Intensive
	rstand that I must cancel existing Aflac Hospital Intensive Care
coverage to purchase this Specified Health Event policy.	chang that I much cancer existing I mad I technicity early
	mher Lunderstand that L will be
torminating handite provided for in my current Ha	mber I understand that I will be spital Intensive Care policy that may not be provided for in the
new Specified Health Event policy.	spital intensive care policy that may not be provided for in the
new Specified Health Event policy.	
 I would prefer to receive an electronic copy of my police 	cy instead of paper. ☐ Yes ☐ No
Any person who knowingly presents a false or fraud	dulent claim for payment of a loss or benefit or knowingly
	rance is guilty of a crime and may be subject to fines and
confinement in prison.	and to gainly or a crime and may no canjour to inico and
ooninienen in prioon.	
Signed and Dated at	on
City and State	Date
ony and otalio	24.0
Proposed Insured's Signature	
Lordify that I parsonally saw the Proposed Insured	when the application was written, and each question was
	corded. All answers above are correct to the best of my
knowledge.	colued. All allowers above are correct to the best of my
kilowiedge.	
Associate's/Agent's Signature	Date
	dent Associate/Agent
Electrica Resi	2011. 1.0000.a.to, 1.go. 1.

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),

CLIENT SERVICES AND ADMINISTRATION,

[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.

FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).

VISIT OUR WEB SITE AT AFLAC.COM.]

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:

ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION

1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR

TOLL-FREE 1-800-852-5494.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- * hospitalization
- * physician services
- * hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- * other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- * Check the coverage in **all** health insurance policies you already have.
- * For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- * For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

REQUEST FOR CHANGE/APPLICATION FOR REINSTATEMENT AND/OR ADDITIONS SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY

American Family Life Assurance Company of Columbus (Aflac) [Worldwide Headquarters • Columbus, Georgia 31999 For information, call toll-free 1-800-99-AFLAC (1-800-992-3522). Fax number: 1-800-448-8922]

			□ Pre-tax	□ After-tax
	Please Print in	Black Ink		
Name of Policyholder				
Last Name		First Name		MI
SSN		Date of Birth		
Policy Type		Policy Number		
Associate's/Agent's Signature			Writing Numbe	r
License	ed Resident Asso	ociate/Agent	Wilding (Validae)	'
PLEASE MAKE TH	HE FOLLOWING	CHANCES TO M	V DOLICY	
PLEASE MAKE IF	1E FOLLOWING	CHANGES TO M	† POLIC †	
□ ADDRESS CHANGE ONLY				
New Address of Policyholder	Otro of			^ - 1 NI -
	Street			Apt. No.
City State	ZIP		Telephone No	
Former Address of Policyholder	Street			^ - 1 NI -
				Apt. No.
City	State		ZIP	
TRANSFERS TO PAYROLL OR UNIO	N BILLING ONL	Y		
Transfer From				
Transfer To		T	ransfer To	
Employer Name			Accou	nt Number
Department No	Employee No			
Amount Remitted \$		Months		
Billing Name				
Last Name		First Name		MI
Effective Date of Transfer				

☐ TRANSFERS T	O DIRECT BILL	ING ONLY				
☐ Bill at Home	■ Bank Draft	□ Cre	edit Card			
Transfer From:						
Direct Billing Mode (sele	ect one) 🛚 Mont	hly (Bank Draft/C	redit Card On	ly) 🛚 Quarterl	ly 🛭 Semiar	nnual 🛚 Annual
Amount Remitted \$			Month	s		
Effective Date of Transf	er					
D NAME CHANC	T ONLY					
□ NAME CHANG						
Name Shown on Policy	Last Na	me	First Na	ıme	MI	Title
Change Name To						
	Last Na	me	First Na	ime	MI	Title
Reason:	riage 🔲 Divor	ce 🖵 Death	☐ Requ	iest		
Payroll/Union Billing Na	me				(if polic	cy is on payroll/union)
Draftee Name					(if po	olicy is on bank draft)
Effective Date of Chang	je					
□ DELETIONS O	NLY					
Person to be Deleted _						
	Last Na	me	First Na	ıme	MI	Title
Sex: ☐ Male	☐ Female					
Relationship: Insur	red 🖵 Spou	se [C hild			
Reason for Deletion	☐ Divorce	☐ Death ☐	Request			
Date of Divorce/Death/F	Request					
New Policy Holder's/Co	ntract Holder's F					
		Last Nam	ie	First Name		MI
Sex: ☐ Male	☐ Female	Birth Date of New	Policy Holder	Contract Holde	er	
Billing Name (if policy of	n payroll/union)_		ast Name	First N	ame	MI
New Coverage Desired	☐ Individual					Insured/Spouse Only
corolago boolloa		_ 0.10 . 0.011.10	y = 1470	. aroner anning		

	ONLY – Complet of application.	e applicable	questions listed	below. Dependen	t Children mus	st be under age
Is anyone to be added N/A If existing cover				yet unborn?		☐ Yes ☐ No
Please note, benefits of the addition. (Con						Effective Date
PLEASE INITIAL:	Policyholder					
Does anyone to be covered have a Specif If yes, please complete under this policy without	ied Health Event the Supplemen	policy that co tal Notification	ntains intensive c below and be aw	are benefits with Afl vare that you canno	lac?	☐ Yes ☐ No
COMPLETE	E IF YOU ARE RE	PLACING/TERI	EMENTAL NOTIFIC MINATING EXISTIN INTENSIVE CARE	G AFLAC COVERAG	SE WHICH CON	ΓAINS
■ My Hospital Inte	ent Policy Numb overage or Spec alth Event Policy nsive Care Polic	er ified Health Ev Number y Number	vent coverage to b	I understand se covered under the	that I must ca is Specified He	ancel my existing alth Event policy.
I understand that I will provided for in the new				пент эресшей пеа	iitri Event polic	y that will hot be
Person(s) to be Added	Last Name		First Name		MI	Title
Sex: ☐ Male	☐ Female					
Relationship:	ouse 🖵 Chi	ld				
Reason for Addition:	■ Marriage	☐ Birth	□ Request			
Date of Marriage/Birth	/Request					
New Policy Holder's/C	ontract Holder's		: Name	First Name		MI
Sex: ☐ Male	☐ Female	Birth Date o	f New Policy Hold	er/Contract Holder		
Billing Name (if policy	on payroll/union)		Last Name	First Nar		MI
New Coverage Desire	d 🗖 Individual	☐ One-Pare		o-Parent Family		

REINSTATEMENT OF OR ADDITIONS TO POLICY ONLY – Complete applicable questions listed below.

ANSWER QUESTIONS 1 THROUGH 10 FOR REINSTATEMENTS OR ADDITIONS ON PAYROLL OR UNION SALES ONLY.

1.	Has anyone to be covered ever been diagnosed with or received medical treatment for any of the following by a member of the medical profession?		☐ Yes ☐ No
	Impaired kidney function (not including stones or acute infection) Cerebral vascular insufficiency Congenital heart disease (excluding surgically corrected atrial septal defect) Heart Attack (two or more)	Cardiomyopathy Stroke or TIA (two or more) Liver disease or disorder (excluding Hepatitis A) Cystic fibrosis Systemic lupus	
2.	Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)?		□ Yes □ No
3.	Has anyone to be covered ever had or been advised to h consulted with or been evaluated by a member of the medi a Major Organ Transplant?		□ Yes □ No
4.	Has anyone to be covered ever been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)?		□ Yes □ No
5.	In the last five years, has anyone to be covered been diagnosed with or received treatment for any of the following by a member of the medical profession?		☐ Yes ☐ No
	Angina Stroke or TIA (single event) Coronary artery disease Angioplasty, stent placement or bypass surgery Chronic obstructive pulmonary disease (COPD)	Atrial fibrillation Arterial blockage Heart Attack (single event) Peripheral vascular disease	
6.	Within the last two years, has anyone to be covered receivement of the medical profession for any medical contreatment for cancer?		□ Yes □ No
7.	Within the last 12 months, has anyone to be covered been with blood thinners, not including aspirin, by a member of the		□ Yes □ No
8.	Within the last 12 months, has anyone to be covered received medical profession in an emergency room or hospital for (not related to pregnancy), or had a medication change to in	hypertension/high blood pressure	□ Yes □ No
9.	Within the last 12 months, has anyone to be covered been prescribed medication for irregular heartbeat, heart palpitation, or tachycardia (not including preventive treatment with antibiotics prior to dental appointment), or has anyone to be covered ever required treatment by a member of the medical profession with a pacemaker or defibrillator?		□ Yes □ No

10.	Within the last six months, has anyone to be covered had or been advised by a member of the medical profession of the need to have diagnostic tests performed to evaluate symptoms of chest pain, shortness of breath, blackouts, fainting, or dizziness?	⊒ Yes □ No	
	If any one of Questions 1 through 10 is answered yes, was it the:		
	☐ Proposed Insured/Employee? ☐ Spouse? ☐ Child? If child, please list the name of the	ne child(ren)	
,	Any person(s) indicated above will not be covered under this policy. If the Proposed Insured/E the policy will not be reinstated; therefore do not submit this application.	Employee,	
	If a Child, are there other children to be covered? □Yes □ No		
PLE	EASE COMPLETE QUESTIONS 11 THROUGH 16 ONLY IF YOU ARE REINSTATING OR MAKING TO PLAN 2, POLICY SERIES A71200, ON PAYROLL OR UNION SALES ONLY.	ADDITIONS	
11.	Are you or anyone to be covered the mother or father of a child currently conceived but as y unborn?	vet □ Yes □ No	
	PLEASE NOTE: Children born within 10 months of the Effective Date of this policy, as show in the Policy Schedule, will not be covered for any losses or confinements that occur or beg within the first 28 days of life.		
	PLEASE INITIAL:		
	Proposed Insured/Employee		
12.	Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization be recommended by a Physician?	en □ Yes □ No	
13.	Has anyone to be covered ever been treated with dialysis (not to include an acute event) or bediagnosed with or treated by a member of the medical profession for chronic kidney disease include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease, or sickle cell anemia	to	
14.	14. Has anyone to be covered ever been diagnosed with or treated by a member of the medica profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea?		
15.	In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery?	he □ Yes □ No	
16.	In the last 12 months, has anyone to be covered received treatment for more than 24 hours in Hospital Intensive Care Unit (not including treatment as a result of an accident)?	a □ Yes □ No	
	If any one of Questions 12 through 16 is answered yes, was it the:		
	☐ Proposed Insured/Employee? ☐ Spouse? ☐ Child? If child, please list the name of the	ne child(ren)	
,	Any person(s) indicated above will not be covered under this policy. If the Proposed Insured/E	Employee,	
	If a Child, are there other children to be covered? □Yes □ No		

	ON NONPAYROLL SALES ONLY.				
1.	Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for any of the following?	□ Yes □ No			
	Any disease, disorder, or abnormality of the heart including, but not limited to, cardiomyopathy, Heart Attack, congestive heart failure, or congenital heart disease (excluding surgically corrected atrial septal defect) Any disease, disorder or abnormality of the circulatory system, including, but not limited to, stroke, TIA, arterial blockage, or cerebral vascular insufficiency Chronic obstructive pulmonary disease (COPD) Cystic fibrosis Type I diabetes Impaired kidney function Kidney disease or disorder (excluding stones or acute infection) or kidney failure Liver disease or disorder (excluding hepatitis A) Systemic lupus Sickle cell anemia				
2.	Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)?	□ Yes □ No			
3.	Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant?	□ Yes □ No			
4.	. Has anyone to be covered ever been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)?				
5.	Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer?				
6.	Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession?	□ Yes □ No			
7.	. Within the last 12 months, has anyone to be covered received treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings?				
8.	Within the last six months, has anyone to be covered had or received treatment by a member of the medical profession for chest pain, shortness of breath, blackouts, fainting, or dizziness, or been advised by a member of the medical profession to have diagnostic tests to evaluate these symptoms?				
	If any one of Questions 1 through 8 is answered yes, was it the:				
	☐ Proposed Insured? ☐ Spouse? ☐ Child? If child, please list the name of the child	(ren).			
Any person(s) indicated above will not be covered under this policy. If the Proposed Insured/Employee, the policy will not be reinstated; therefore do not submit this application.					

COMPLETE NUMBERS 1 THROUGH 9 FOR ADDITIONS AND REINSTATEMENTS

Form A71003RAR 7 of 7 A71003RAR.1

If a Child, are there other children to be covered?

☐Yes ☐ No

-		
9.	Please list your height and weight: Height: ft. in. Weight: lbs.	
	Additional underwriting may be required.	
PLE	ASE COMPLETE QUESTIONS 10 THROUGH 17 ONLY IF YOU ARE REINSTATING OR MAKING AI TO PLAN 2, POLICY SERIES A71200, ON NONPAYROLL SALES ONLY.	DDITIONS
10.	Are you or anyone to be covered the mother or father of a child currently conceived but as yet unborn?	□ Yes □ No
	PLEASE NOTE: Children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life.	
	PLEASE INITIAL: Proposed Insured/Employee	
11.	Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician?	☐ Yes ☐ No
12.	Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease?	□ Yes □ No
13.	Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea?	□ Yes □ No
14.	In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery?	☐ Yes ☐ No
15.	Has anyone to be covered been hospitalized three or more times in the last two years?	☐ Yes ☐ No
16.	In the last 12 months, has anyone to be covered received treatment in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit (not including treatment as a result of an accident)?	☐ Yes ☐ No
17.	In the last 12 months, has anyone to be covered been prescribed or taken any medication for the treatment of infertility?	☐ Yes ☐ No
	If any one of Questions 11 through 17 is answered yes, was it the: □ Proposed Insured? □ Spouse? □ Child? If child, please list the name of the child(ren)	

I understand that the reinstated policy will cover only loss resulting from a covered Primary or Secondary Specified Health Event or hospitalization that occurs more than ten days after the date of reinstatement. I understand that the information on this form applies **ONLY** to my Aflac Specified Health Event policy.

Any person(s) indicated above will not be covered under this policy. If the Proposed Insured/Employee, the policy will not be reinstated; therefore do not submit this application.

If a Child, are there other children to be covered?

I have read, or had read to me, the completed application, and I realize that policy reinstatement is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of Form A71003RAR

7 of 7

A71003RAR.1

☐Yes ☐ No

coverage under the policy. I understand that Aflac and I will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy in connection with the reinstatement. I further understand that coverage under the reinstated policy is subject to the terms set forth in my policy's Reinstatement Provision.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature			
Signed and Dated at		on	
	City and State		Date

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC. [FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522). VISIT OUR WEB SITE AT AFLAC.COM.]

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:

ARKANSAS INSURANCE DEPARTMENT - CONSUMER SERVICES DIVISION

1200 WEST THIRD STREET
LITTLE ROCK, ARKANSAS 72201-1904
Telephone (501) 371-2640 or Toll-Free 1-800-852-5494

SERFF Tracking Number: AFLA-126789903 State: Arkansas
Filing Company: American Family Life Assurance Company of State Tracking Number: 46768

Columbus

Company Tracking Number: A71000RAPPS

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness

Limited Benefit

Product Name: Payroll, Union and Non-payroll Specified Health Event Application Forms

Project Name/Number: A71000 applications/A71001RAR

Supporting Document Schedules

Item Status: Status

Date:

Satisfied - Item: Flesch Certification Approved-Closed 09/24/2010

Comments:

A filing description letter signed by a company officer is attached with the following certifications:

I certify that the following forms comply with the requirements of Arkansas Statue Annotated Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act.

I certify that the forms submitted herewith meet the: applicable provision of Rule and Regulation 19 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of Arkansas Insurance Department.

I certify that the forms submitted herewith meet the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

Attachment:

A71000 revapps.pdf

Item Status: Status

Date:

Satisfied - Item: Application Approved-Closed 09/24/2010

Comments:

For your reference the applications previously approved on March 14, 2007, and the stamped approval are attached below.

Attachments:

A71000 revapps 20070314 STMPD APPRVL.pdf A71001ARR1.pdf A71001AARR1.pdf A71002ARR1.pdf A71002AARR1.pdf A71003ARR1.pdf SERFF Tracking Number: AFLA-126789903 State: Arkansas 46768

Filing Company: American Family Life Assurance Company of State Tracking Number:

Columbus

Company Tracking Number: A71000RAPPS

TOI: H07I Individual Health - Specified Disease -Sub-TOI: H07I.001 Critical Illness

Limited Benefit

Product Name: Payroll, Union and Non-payroll Specified Health Event Application Forms

A71000 applications/A71001RAR Project Name/Number:

> **Item Status:** Status

> > Date:

Satisfied - Item: Outline of Coverage Approved-Closed 09/24/2010

Comments:

The applications submitted for approval will be used with Outline of Coverage Forms A71125AR and A71225AR which were also approved on March 28, 2006. For your convenience a copy of the previously approved Outline of Coverage Forms and stamped approval are attached below.

Attachments:

A71125AR.pdf A71225AR.pdf

A71000 STMPD APPRVL.pdf



Deborah T. Grantham AIRC, HIA, ACSSecond Vice President
Compliance Department

September 13, 2010

Life and Health Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

NAIC # 60380

Re: Specified Health Event Payroll and Union Application Forms A71001RAR and A71001L1AR, Non-payroll Application Forms A71002RAR and A71002RCAR, and Request for Change/Application for Reinstatement and/or Additions Form A71003RAR

Dear Commissioner:

Referenced forms are submitted for your review and approval. Similar versions of these forms were previously approved by your department on March 14, 2007. These applications will be used with Policy Forms A71100 and A71200 which were also approved on March 28, 2006, and will replace the previously approved applications.

Revisions were made in order to simplify the underwriting questions, add a Union option, and update the formatting to be consistent with our more recent applications.

The only difference between A71002RAR and A71002RCAR is that A71002RAR does NOT contain an agent certification statement. Form A71002RAR will be used in situations where the associate/agent is unable to be present at the time of application. Payroll/Union Application Form A71001L1AR differs from Form A71001RAR in that it only offers Plan 1 Policy Form A71100AR.

Any form numbers that were previously approved have been revised by adding an "R" to reflect the changes.

I certify that the following forms comply with the requirements of Arkansas Statue Annotated Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act. I further certify the scores for each form are as follows:

		<u>FLESCH</u>
		Score
Payroll and Union Application Form	A71001RAR	57.17
Payroll and Union Application Form	A71001L1AR	70.90
Non-payroll Application Form	A71002RAR	71.04
Non-payroll Application Form	A71002RcAR	70.12
Request for Change/Application for Reinstatement and/or Additions Form	A71003RAR	72.19

I certify that the forms submitted herewith meet the applicable provisions of Rule and Regulation 18 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of the Arkansas Insurance Department.

I certify that the forms submitted herewith meet the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

The filing fee of \$250 is submitted by EFT in this SERFF filing. FLESCH certification is provided above. A copy of the prior approval is included under the Supporting Documentation tab for your convenience. This will not affect any rates on file that were approved on March 28, 2006. An actuarial memorandum and rates are enclosed for Union.

Aflac reserves the right to alter the format of the forms without re-filing due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to wording or content would be filed for prior approval. We also reserve the right to use these forms in an electronic format, but Aflac certifies we will retain the filed final print format. We have included brackets in all forms around the address, telephone number, and web site in the event these change in the future. Other bracketed information includes language that may or may not appear based on whether the account is Payroll or Union. The certification statement above the agent's signature may or may not appear based on whether or not the agent is present at the time of application.

This filing has been prepared by Connie Gates. Should you have any questions concerning this submission, please do not hesitate to call her collect at (706) 596-5048, by fax at (706) 660-7080 or email at cgates@aflac.com.

Sincerely,

Deborah T. Grantham

Deboral Shantta

DTG/CG/cg Enclosures



COM

Rita S. Golden, HIA, AIRC, ACS, MHP

Director, Regulatory Compliance Compliance Department

March 06, 2007

RECEIVED

MAR 2 0 2007

COMPLIANCE DEPT.

Mr. Joe Musgrove
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

RECEIVED
MAR 1 2 2007

LIFE AND HEALTH ARKANSAS INSURANCE DEPARTMENT

MAR 14 2007

ARKANSAS INSURANCE DEPARTMENT

RE: Application Forms A47001ARR, A47001AARR, A71001ARR1, A71001AARR1, A71002ARR1 and A71002AARR1.

Reinstatement Application Forms A18403ARR1, A45003ARR1, A45003DARR1, A46003ARR1, A47003ARR1, A4700ARR1, A47

Dear Mr. Musgrove:

The above referenced applications are submitted for your review and approval.

The chart below lists the new forms, the policy forms with which the applications will be used, and the original policy approval date of the forms.

Application Form #	To be used with Policy Form #	Replaces Form #	Policy Approval Date
A18403ARR1	A18400AR and A1840HAR	A18403RR	10/27/2006
A45003ARR1	A-45100-AR, A-45200-AR & A-45300-AR	A45003ARR	01/04/2007
A45003DARR1	A-45100-AR, A-45200-AR & A-45300-AR	A45003DARR	01/04/2007
A46003ARR1	A46100AR, A46200AR & A46300AR	A46003ARR	01/04/2007
A47001ARR	A47100AR and A47200AR	A47001AR	09/13/2006
A47001AARR	A47100AR and A47200AR	A47001AAR	09/13/2006
A47003ARR	A47100AR and A47200AR	.A47003AR	09/13/2006
A71001ARR1	A71100AR and A71200AR	A71001ARR	10/27/2006
A71001AARR1	A71100AR and A71200AR	A71001AARR	10/27/2006
A71002ARR1	A71100AR and A71200AR	A71002ARR	10/27/2006
A71002AARR1	A71100AR and A71200AR	A71002AARR	10/27/2006
A71003ARR1	A71100AR and A71200AR	A71003ARR	10/27/2006

The changes to the applications are in the underwriting portion of the applications. The following question was added:

Is anyone to be covered the mother or father of a child currently conceived but as yet	Yes No
unborn?	

Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life.

PLEASE INITIAL:			
	Proposed	Insured/Employe	e

Mr. Joe Musgrove Arkansas Insurance Department March 06, 2007

Please note, Application Forms A71001ARR1, A71001AARR1, A71002ARR1 and A71 slightly different from the other Application Forms as the language is more specific to the following question was added:	
Is anyone to be covered the mother or father of a child currently conceived but as yet unborn?	□ Yes □ No
Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.	
PLEASE INITIAL:	
Proposed Insured	
The changes to the reinstatement applications are in the ADDITIONS ONLY section and portion. The following questions were added:	the underwriting
Additions Only section:	
Is anyone to be added the mother of a child currently conceived but as yet unborn? Please note, benefits are not payable for pregnancy or childbirth within the first 10 months of the Effective Date of the addition. (Complications of Pregnancy will be covered to the same extent as a Sickness).	🗅 Yes 🗅 No
PLEASE INITIAL:	
Policyholder	
<u>Underwriting section:</u>	
Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? Please note, children born within 10 months of the reinstatement Effective Date	□ Yes □ No
of this policy will not be covered for any losses or confinements that occur or begin within the first 28 days of life.	
PLEASE INITIAL: Policyholder	
Please note the Reinstatement Application Form A71003ARR1 is slightly different Reinstatement Application Forms as the language is more specific to the product. The folwas added:	
Is anyone to be covered the mother or father of a child currently conceived but as yet unborn?	□ Yes □ No
Please note, children born within 10 months of the reinstatement Effective Date of this policy will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.	
PLEASE INITIAL:Policyholder	

Mr. Joe Musgrove Arkansas Insurance Department March 06, 2007

Aflac certifies that the above revisions are the only changes made to the previously approved forms.

The appropriate filing fee, accompanying fee certification form and FLESCH certification form are enclosed. This will not affect any rates that were approved.

I certify that the forms submitted herewith comply with the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

I certify that the forms submitted herewith meet the applicable provisions of Rule and Regulation 18 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of the Arkansas Insurance Department.

This filing has been prepared by Connie Gates. Should you have any questions concerning this filing, please do not hesitate calling her collect at (706) 596-5048, by faxing her at (706) 660-7080 or by emailing her at cgates@aflac.com. A return envelope is enclosed for your convenience to reply.

Sincerely,

Rita S. Golden RG/CG/cg

Golden

Enclosures



SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY (A71000 Series)

Supplemental Health Insurance Coverage
Application to: American Family Life Assurance Company of Columbus (Aflac) Worldwide Headquarters • Columbus, Georgia 31999

Policy	Number:

□ Conversion

■ New

Please Print in Black Ink – To Be Completed by Proposed Insured/Employee							
Proposed Insured's	Name						
		Last		Fir	rst		MI
DOBMonth/Day		Sex	S	SN			-
Month/Day	/Year						
Are you applying fo	r Dependent Child	(ren) coverage?	□Yes [⊒No			
		nder age 25 at the tir					
		are applying for Two use is not to be cove					only coverage;
Spouse's Name				DO	ОВ		Sex
Las	st	First	М	I	Mo	onth/Day/Yea	Sex
Address							
AddressStr	eet or Post Office	Вох				Apt. No	
City			State		7IP		
Only			<u> </u>		<u> </u>		
Home Telephone ()						
Employee's							
Name	oth or their Dranes	ed Insured)	R	elationship			
(11.0	other than Propose	ea insurea)					
Payroll Account Na	me			Payroll A	ccount No	0	
							(Optional)
		any other health insulucement Notice provi			ant if ann	olicable	☐ Yes ☐ No
		other Specified Hea				nicable.	☐ Yes
□ No							
		at coverage. If yes,		ent policy numbe	er and see	e Item 25.	
Does anvone to be	covered have any	Hospital Intensive C	are cove	rage with Aflac?			☐ Yes ☐ No
		Policy Series A71200			oital		
		If desired, please co					
	application and be aware that you cannot have Plan 2 of the Specified Health Event policy without canceling your existing Hospital Intensive Care policy with Aflac.						
Tiospital intensive Care policy with Allac.							
	ТО	BE COMPLETED BY	Y AFLAC	ASSOCIATE/A	GENT		
Check Coverage Desired:	☐ Individual	□ Named Insured Spouse Only	/ 🗆	One-Parent Far	mily	☐ Two-Pa	rent Family
	d Health Event Onl	y (Policy Series A71	100)			<u> </u>	☐ Pre-Tax
☐ Plan 2: Specified	☐ Plan 2: Specified Health Event with Hospital Intensive Care Unit Benefits (Policy Series A71200) or						
		Rider (Rider Series A					□ After-Tax
☐ Primary Specified Health Event Recovery Rider (Rider Series A71051)							

☐ Pay	Method: roll Deduction roll ACH	Mode: ☐ 01 Weekly ☐ 01 14-Day Biweekly ☐ 01 28-Day Biweekly	□ 01 Monthly □	06 Semiannual 12 Annual
Employ	ree ID No	Dept. No	Assoc./Agen	t's No
Billable	Premium \$	Premium Collect	ed \$ Sit. Co	de
	PLEASE COMPL	ETE QUESTIONS 1 THROUG	H 11 IF APPLYING FOR PLAN 1	OR PLAN 2.
1.	the following by a mem Impaired kidney for (not including s Cerebral vascular Congenital heart	nber of the medical profession? unction stones or acute infection) r insufficiency disease gically corrected atrial septal de	Cardiomyopathy Stroke or TIA (two or more Liver disease or disorder (excluding Hepatitis A)	☐ Yes ☐ No
2.	member of the medica five years, or (2) with c	al profession for diabetes (1) recomplications to include retinop	with or received medical treatment equiring the use of insulin within the athy, neuropathy, or nephropathy, or to age 30 (excluding gestational)?	ne last or
3.		evaluated by a member of the	ed to have a Major Organ Transple medical profession of the need to	
4.	immune deficiency syn		with or medically treated for acoust the medical profession, or has a liency virus (HIV)?	
5.	treatment for any of the Angina Stroke or TIA (sir Coronary artery of Angioplasty, sten	e following by a member of the ngle event)	Atrial fibrillation Arterial blockage Heart Attack (single event) Peripheral vascular diseas	□ Yes □ No
6.			d received chemotherapy treatment cal condition, not to include hore	
7.		nths, has anyone to be covered tincluding aspirin, by a member	d been prescribed or received trea er of the medical profession?	atment □ Yes □ No
8.	member of the medica	al profession in an emergency	vered received medical treatment verom or hospital for hypertension a medication change to improve	n/high

9.	Within the last 12 months, has anyone to be covered been prescribed medication for irregular heartbeat, heart palpitation, or tachycardia (not including preventive treatment with antibiotics prior to dental appointment), or has anyone to be covered ever required treatment by a member of the medical profession with a pacemaker or defibrillator?	□ Yes □ No
10.	Within the last six months, has anyone to be covered had or been advised by a member of the medical profession of the need to have diagnostic tests performed to evaluate symptoms of chest pain, shortness of breath, blackouts, fainting, or dizziness?	□ Yes □ No
11.	If any one of Questions 1 through 10 is answered yes, was it the:	
	☐ Proposed Insured/Employee? ☐ Spouse? ☐ Child? If child, please list the name of	the child(ren)
	Any person(s) so designated will not be covered under the policy. If the person named is the Proposed Insured/Employee named on the front of this applia a policy will not be issued.	cation,
	PLEASE ONLY COMPLETE QUESTIONS 12 THROUGH 18	
	IF YOU ARE APPLYING FOR PLAN 2, POLICY SERIES A71200.	
12.	Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.	□ Yes □ No
	PLEASE INITIAL:	
13.	Proposed Insured Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician?	□ Yes □ No
14.	Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease, or sickle cell anemia?	□ Yes □ No
15.	Has anyone to be covered ever been diagnosed with or medically treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea?	□ Yes □ No
16.	In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery?	□ Yes □ No
17.	In the last 12 months, has anyone to be covered received treatment for more than 24 hours in a Hospital Intensive Care Unit (not including treatment as a result of an accident)?	□ Yes □ No
18.	If any one of Questions 13 through 17 is answered yes, was it the:	
	☐ Proposed Insured/Employee? ☐ Spouse? ☐ Child? If child, please list the name of the	e child(ren).
	Any person(s) so designated will not be covered under the policy. If the person named is the Proposed Insured/Employee named on the front of this applia policy will not be issued.	cation,

APPLICANT'S STATEMENTS AND AGREEMENTS:

- 19. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
- 20. I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The Intensive Care Benefits A, B, and J of the Plan 2 policy (Series A71200) reduce to half at age 70.
- 21. I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.
- 22. I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
- 23. I acknowledge receipt of, if applicable:

 ☐ Replacement Notice
 ☐ Guide To Health Insurance for People with Medicare
 ☐ Outline of Coverage
- 24. I understand that the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application and that: (a) Aflac is not bound by any statement made by me, the Proposed Insured/Employee or any associate/agent of Aflac unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- 25. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 1 through 10 or 13 through 17 is answered yes, the policy for which this application is made for the person(s) identified in Item 11 or Item 18 will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force. (b) The Time Limit on Certain Defenses provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy. (c) The Pre-Existing Conditions provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-Existing Conditions provision in the new policy will run from the new policy's Effective Date.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

SUPPLEMENTAL NOTIFICATION				
COMPLETE IF YOU ARE REPLACING		OSPITAL INTENSIVE CARE COVERAGE.		
l,		ecified Health Event Policy (Plan 2), which		
		are benefits under Aflac's Hospital Intensive		
Care Policy Number	I understand that I must ca	ancel existing Aflac Hospital Intensive Care		
coverage to purchase this Specified Healt				
Please cancel my Hospital Intensive				
terminating benefits provided for in	n my current Hospital Intensive Car	re policy that may not be provided for in the		
new Specified Health Event policy.				

I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf, and I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me by my associate/agent.

I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the Aflac policy. I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated at		on	
-	City and State		Date
Proposed Insured/Employee Sig	gnature		
I certify that I personally sa question was asked of the I correct to the best of my know	Proposed Insured/Employee	nployee when the application was and answered as recorded. All	s written, and each answers above are
Associate's/Agent's Signature _		Date	
	Licensed Resident Ass	sociate/Agent	
AMERICAN FAMILY LIF	FE AŠSURANCE COMPANY O ADMINISTR	following – it will become part of the p F COLUMBUS (AFLAC), CLIENT SI ATION, 99 TOLL-FREE 1-800-99-AFLAC (1-	ERVICES AND
Associate/Agent's Name			
Associate/Agent's Address		Telephone	

If we at AFLAC fail to provide you with reasonable and adequate service, you should feel free to contact:

ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION

1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR

TOLL-FREE 1-800-852-5494.

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC. FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522). VISIT OUR WEB SITE AT AFLAC.COM. For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- * hospitalization
- * physician services
- * hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- * other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- * Check the coverage in **all** health insurance policies you already have.
- * For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- * For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).



SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY (A71000 Series)

Supplemental Health Insurance Coverage
Application to: American Family Life Assurance Company of Columbus (Aflac) Worldwide Headquarters • Columbus, Georgia 31999

Policy Number:	_

□ Conversion

■ New

	Please Print in E	Black Ink – To Be C	Complete	ed by Propose	d Insured/E	mployee		
Proposed Insured's	Name				_			
•		Last			First			MI
DOBMonth/Day/	S	Sex	;	SSN				
Month/Day/	Year							
Are you applying fo	r Dependent Child	(ren) coverage?	□Yes	□No				
If yes, Dependent C								
Write spouse's na if you have no spo							Only cov	erage;
Spouse's Name					DOB		Sex	
Las		First	I	MI	Me	onth/Day/Yea	ar	
Address								
Str	eet or Post Office	Box				Apt. No).	_
City			State		ZIP			
Home Telephone ()		-					
Employee's								
Name				Relationship _				
(11 (other than Propose	ed Insured)						
Payroll Account Na	me			Payro	II Account N	0		
la this incomes int				ow in force?			(Optional	,
Is this insurance intended to replace any other health insurance now in force? Yes No Yes No								
Does anyone to be covered have any other Specified Health Event coverage with Aflac?								
□ No		. (- Itaa- 05		
If yes, this must be Policy Number:	a conversion of th	at coverage. If yes	s, give cu	rrent policy nui	mber and se	e item 25.		
Does anyone to be	covered have any	Hospital Intensive	Care cov	erage with Afla	ac?		☐ Yes	□ No
If yes, you may not	apply for Plan 2 (F	Policy Series A7120	0) unless	the existing H	lospital			
Intensive Care policapplication and be								
Hospital Intensive C			trie Spe	cilled Health E	vent policy w	villiout carice	illig your	existing
						7		
	ТО	BE COMPLETED E	BY AFLA	C ASSOCIAT	E/AGENT			
Check Coverage	☐ Individual	□ Named Insure	ed/	One-Parent	Family	☐ Two-Pa	arent Fan	nily
Desired:		Spouse Only	1100)					
□ Plan 1: Specified Health Event Only (Policy Series A71100) □ Pre-Tax □ Plan 2: Specified Health Event with Hospital Intensive Care Unit Benefits (Policy Series A71200) or								
□ Plan 2: Specified Health Event with Hospital Intensive Care Unit Benefits (Policy Series A71200) or □ First Occurrence Building Benefit Rider (Rider Series A71050) (\$500) □ After-Tax								
□ Primary Specified Health Event Recovery Rider (Rider Series A71051)								

☐ Pay	y Method: yroll Deduction yroll ACH yee ID No.		01 Weekly 01 14-Day Biweekly 01 28-Day Biweekly Dept. No		Ass	□ oc./Age		
Billable	e Premium \$		Premium Collecte	3d \$		Sit. C	ode	
	PLEASE COMPL	ETE Q	UESTIONS 1 THROUG	H 11	IF APPLYING FOR	PLAN	1 OR PLA	AN 2.
1.	the following by a member impaired kidney further (not including storage). Cerebral vascular Congenital heart d	er of to nction ones co insuffici isease cally co	or acute infection) ciency e orrected atrial septal defe		Ceived medical treatr Cardiomyopathy Stroke or TIA (two Liver disease or di (excluding Hep Cystic fibrosis Systemic lupus	or more	e)	□ Yes □ No
2.	member of the medical five years, or (2) with co	profes mplica	ever been diagnosed wi ssion for diabetes (1) red ations to include retinopate, or (4) diagnosed prior t	quirii thy, i	ng the use of insulin neuropathy, or nephro	within opathy,	the last or	□ Yes □ No
3.		evaluat	ver had or been advised ted by a member of the n					☐ Yes ☐ No
4.	deficiency syndrome (A	IDS) I	er been diagnosed with o by a member of the me man immunodeficiency vi	edica	l profession, or has			☐ Yes ☐ No
5.	treatment for any of the Angina Stroke or TIA (sind Coronary artery di Angioplasty, stent	followi gle eve sease placer				ge le event	t)	□ Yes □ No
6.			s anyone to be covered fession for any medica					☐ Yes ☐ No
7.			s anyone to be covereding aspirin, by a member				eatment	□ Yes □ No
8.	of the medical profess	ion in	anyone to be covered re an emergency room c nancy), or had a medica	r ho	spital for hypertens	ion/high	n blood	□ Yes □ No
9.	heartbeat, heart palpitate prior to dental appoint	ion, oi ment),	s anyone to be covered to tachycardia (not includite or has anyone to be sion with a pacemaker or	ng p	reventive treatment vered ever required to	with an	tibiotics	□ Yes □ No

10.	Within the last six months, has anyone to be covered had or been advised by a member of the medical profession of the need to have diagnostic tests performed to evaluate symptoms of chest pain, shortness of breath, blackouts, fainting, or dizziness?	□ Yes □ No
11.	If any one of Questions 1 through 10 is answered yes, was it the:	
	☐ Proposed Insured/Employee? ☐ Spouse? ☐ Child? If child, please list the name of	the child(ren)
	Any person(s) so designated will not be covered under the policy. If the person named is the Proposed Insured/Employee named on the front of this applia policy will not be issued.	ication,
	PLEASE ONLY COMPLETE QUESTIONS 12 THROUGH 18 IF YOU ARE APPLYING FOR PLAN 2, POLICY SERIES A71200.	
12.	Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.	☐ Yes ☐ No
	PLEASE INITIAL:	
13.	Proposed Insured Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician?	□ Yes □ No
14.	Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease, or sickle cell anemia?	□ Yes □ No
15.	Has anyone to be covered ever been diagnosed with or medically treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea?	□ Yes □ No
16.	In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery?	□ Yes □ No
17.	In the last 12 months, has anyone to be covered received treatment for more than 24 hours in a Hospital Intensive Care Unit (not including treatment as a result of an accident)?	□ Yes □ No
40	If any one of Overtions 42 through 47 is an average use were it the	
18.	If any one of Questions 13 through 17 is answered yes, was it the: ☐ Proposed Insured/Employee? ☐ Spouse? ☐ Child? If child, please list the name of the	e child(ren).
	Any person(s) so designated will not be covered under the policy. If the person named is the Proposed Insured/Employee named on the front of this appliance application of the insured.	ication,

APPLICANT'S STATEMENTS AND AGREEMENTS:

- 19. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
- 20. I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The Intensive Care Benefits A, B, and J of the Plan 2 policy (Series A71200) reduce to half at age 70.
- 21. I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.
- 22. I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
- 23. I acknowledge receipt of, if applicable:

 ☐ Replacement Notice
 ☐ Guide To Health Insurance for People with Medicare
 ☐ Outline of Coverage
- 24. I understand that the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application and that: (a) Aflac is not bound by any statement made by me, the Proposed Insured/Employee or any associate/agent of Aflac unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- 25. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 1 through 10 or 13 through 17 is answered yes, the policy for which this application is made for the person(s) identified in Item 11 or Item 18 will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force. (b) The Time Limit on Certain Defenses provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy. (c) The Pre-Existing Conditions provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-Existing Conditions provision in the new policy will run from the new policy's Effective Date.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

	SUPPLEMENTAL NOTIFICATION	
COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC HOSPITAL INTENSIVE CARE COVERAGE.		
l,	, am applying for Aflac's Specified Health Event Policy (Plan 2), which	
	s. I currently have hospital intensive care benefits under Aflac's Hospital Intensive	
	I understand that I must cancel existing Aflac Hospital Intensive Care	
coverage to purchase this Specified Heal	alth Event policy.	
	ive Care Policy Number I understand that I will be	
	in my current Hospital Intensive Care policy that may not be provided for in the	
new Specified Health Event policy.	y.	

I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf, and I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me by my associate/agent.

I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the Aflac policy. I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated at	on
City and State	Date
Proposed Insured/Employee Signature	
Associate's/Agent's SignatureLicensed Resi	dent Associate/Agent
AMERICAN FAMILY LIFE ASSURANCE COM ADI	lete the following – it will become part of the policy. PANY OF COLUMBUS (AFLAC), CLIENT SERVICES AND MINISTRATION, BIA, 31999 TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
Associate/Agent's Name	
Associate/Agent's Address	Telephone

If we at AFLAC fail to provide you with reasonable and adequate service, you should feel free to contact:

ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION

1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR

TOLL-FREE 1-800-852-5494.

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC. FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522). VISIT OUR WEB SITE AT AFLAC.COM. For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- * hospitalization
- * physician services
- * hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- * other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- * Check the coverage in **all** health insurance policies you already have.
- * For more information about Medicare and Medicare Supplement insurance, review the Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare, available from the insurance company.
- * For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).



SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY (A71000 Series)

Supplemental Health Insurance Coverage
Application to: American Family Life Assurance Company of Columbus (Aflac)

Worldwide Headquarters • Columbus, Georgia 31999

ш	ivew
	Conversion

Policy Number:

	D: (: D)			
Please	Print in Black Ink – To	Be Completed by	Proposed Insured	
Proposed Insured's Name				
L	ast	Firs	st	MI
DOR	Sex	SSN		
DOBMonth/Day/Year	Jex	3311		
·				
State of Birth:	Are you applyin	g for Dependent C	hild(ren) coverage?	□Yes □No
	If yes, Dependent Child	dren must be unde	r age 25 at the time of	application.
Write spouse's name below if ye	ou are applying for Two	o-Parent Family o	r Named Insured/Spo	use Only coverage:
if you have no spouse or your s				, ,
Spouse's Name	F ' (B 41	DOB	
Last	First	MI	Month/Day/Ye	ar
Address				
Street or Post Off	ice Box		Aı	ot. No.
		_		
City		State	ZIP	
Home Telephone ()				
Tiome releptione ()				
Name of Employer/Association			Account No	
-				(Optional)
Is this insurance intended to repla	ice any other health insu	rance now in force	?	☐ Yes ☐ No
If yes, please read and sign the R				
Does anyone to be covered have				☐ Yes ☐ No
If yes, this must be a conversion of	of that coverage. If yes,	give current policy	number and see Item 2	26.
Policy Number:				
Does anyone to be covered have				☐ Yes ☐ No
If yes, you may not apply for Plan				at the and af this
Intensive Care policy is terminated				
application and be aware that you Hospital Intensive Care policy with		ie Specilied Healtr	i Event policy without o	anceling your existing
Hospital intensive Care policy with	I Allac.			
Γ	TO BE COMPLETED B	Y AFLAC ASSOC	CIATE/AGENT	
Check Coverage ☐ Individua		/ ☐ One-Par	ent Family	□ Two-Parent
Desired:	Spouse Only			Family
☐ Plan 1: Specified Health Event				
Plan 2: Specified Health Event			(Policy Series A71200)	
☐ First Occurrence Building Bene				
Primary Specified Health Event	t Recovery Rider (Rider	Series A71051)		
Dilling Mathead		Mada.		
Billing Method:	Temp Nonnoveell/Acce	Modes:	hly (B/D o C/C Only)	D 06 Comionaval
	Emp. Nonpayroll/Asso		hly (B/D & C/C Only)	06 Semiannual12 Annual
· · · · · · · · · · · · · · · · · · ·	Credit Card (C/C)	☐ 03 Quar	ıcııy	■ 12 AIIIIUal
☐ List Bill Card Name				
Card Name				
Card No.			Expiration Date	

VISA/I Premi	Ithorize American Family Life Assurance Company of Columbus (Aflac) to MASTERCARD/AMERICAN EXPRESS account in accordance with the premium rate that I ums will be advanced by my bank until I cancel authorization in writing to Aflac. Cancellation will be easy of the month following Aflac's receipt of notice to cancel.	charge my have chosen. ffective on the
Signat Assoc	ure Date iate's/Agent's No Sit. Code Billable Premium \$ Premium Collecte	ed \$
	PLEASE COMPLETE QUESTIONS 1 THROUGH 10 IF APPLYING FOR PLAN 1 OR PLAN 2	2.
1.	Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for any of the following?	□ Yes □ No
	Any disease, disorder, or abnormality of the heart including, but not limited to, cardiomyopathy, Heart Attack, congestive heart failure, or congenital heart disease (excluding surgically corrected atrial septal defect) Any disease, disorder or abnormality of the circulatory system, including, but not limited to, stroke, TIA, arterial blockage, or cerebral vascular insufficiency Chronic obstructive pulmonary disease (COPD) Cystic fibrosis Type I diabetes Impaired kidney function Kidney disease or disorder (excluding stones or acute infection) or kidney failure Liver disease or disorder (excluding hepatitis A) Systemic lupus Sickle cell anemia	
2.	Has anyone to be covered ever been diagnosed with or received medical treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)?	□ Yes □ No
3.	Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant?	□ Yes □ No
4.	Has anyone to be covered ever been diagnosed with or medically treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)?	□ Yes □ No
5.	Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer?	□ Yes □ No
6.	Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession?	☐ Yes ☐ No
7.	Within the last 12 months, has anyone to be covered received medical treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings?	□ Yes □ No
8.	Within the last six months, has anyone to be covered had or received treatment by a member of the medical profession for chest pain, shortness of breath, blackouts, fainting, or dizziness, or been advised by a member of the medical profession to have diagnostic tests to evaluate these symptoms?	□ Yes □ No

9.	If any one of Questions 1 through 8 is answered yes, was it the:	
	☐ Proposed Insured? ☐ Spouse? ☐ Child? If child, please list the name of the child(red	n).
If the	Any person(s) so designated will not be covered under the policy. e person named is the Proposed Insured named on the front of this application, a policy will no	t be issued.
10.	Please list your height and weight: Height: ft. in. Weight: lbs.	
	Additional underwriting may be required.	
	PLEASE ONLY COMPLETE QUESTIONS 11 THROUGH 19 IF APPLYING FOR PLAN 2, POLICY SERIES A71200.	
11.	Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.	□ Yes □ No
	PLEASE INITIAL:	
12.	Proposed Insured Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician?	□ Yes □ No
13.	Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease?	□ Yes □ No
14.	Has anyone to be covered ever been diagnosed with or medically treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea?	□ Yes □ No
15.	In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery?	□ Yes □ No
16.	Has anyone to be covered been hospitalized three or more times in the last two years?	☐ Yes ☐ No
17.	In the last 12 months, has anyone to be covered received treatment in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit (not including treatment as a result of an accident)?	□ Yes □ No
18.	In the last 12 months, has anyone to be covered been prescribed or taken any medication for the treatment of infertility?	□ Yes □ No
19.	If any one of Questions 12 through 18 is answered yes, was it the:	
	☐ Proposed Insured? ☐ Spouse? ☐ Child? If child, please list the name of the child(re	n).
I£ 41	Any person(s) so designated will not be covered under the policy.	t be issued

APPLICANT'S STATEMENTS AND AGREEMENTS:

- 20. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
- 21. I understand that the policy I am applying for will not cover any person who has attained age 65 before the Effective Date of the policy. The Intensive Care Benefits A, B, and J of the Plan 2 policy (Series A71200) reduce to half at age 70.
- 22. I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.
- 23. I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
- 24. I acknowledge receipt of, if applicable:

 □ Replacement Notice
 □ Guide to Health Insurance for People with Medicare
 □ Outline of Coverage
- 25. I understand that the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application and that: (a) Aflac is not bound by any statement made by me, the Proposed Insured or any associate/agent of Aflac unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- 26. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 1 through 8 or 12 through 18 is answered yes, the policy for which this application is made for the person(s) identified in Item 9 or Item 19 will be void, and coverage will continue for this person under the terms of the previous policy, if such policy remains in force. (b) The Time Limit on Certain Defenses provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy. (c) The Pre-Existing Conditions provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-Existing Conditions provision in the new policy will run from the new policy's Effective Date.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

	SUPPLEMENTAL NOTIFICATION
COMPLETE IF YOU ARE REPLACING	/TERMINATING EXISTING AFLAC HOSPITAL INTENSIVE CARE COVERAGE.
I,	, am applying for Aflac's Specified Health Event Policy (Plan 2), which
contains hospital intensive care benefits. I	currently have hospital intensive care benefits under Aflac's Hospital Intensive
Care Policy Number	I understand that I must cancel existing Aflac Hospital Intensive Care
coverage to purchase this Specified Health	n Event policy.
Please cancel my Hospital Intensive	Care Policy Number I understand that I will be
terminating benefits provided for in	my current Hospital Intensive Care policy that may not be provided for in the
new Specified Health Event policy.	

I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the Aflac policy. I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

complete and true. All statements made in this application are deemed representations and not warranties. I realize that

any material misrepresentation therein may result in loss of coverage under the policy.

Signed and Dated at	on
City and State	Date
Proposed Insured's Signature	
	nen the application was written, and each question was rded. All answers above are correct to the best of my
Associate's/Agent's Signature	Date
	at Associate/Agent
AMERICAN FAMILY LIFE ASSURANCE COMPANY ADMINIS	e following – it will become part of the policy. OF COLUMBUS (AFLAC), CLIENT SERVICES AND TRATION, 1999 TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
Associate/Agent's Name	
Associate/Agent's Address	Telephone

If we at AFLAC fail to provide you with reasonable and adequate service, you should feel free to contact:

ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION

1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR

TOLL-FREE 1-800-852-5494.

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC. FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522). VISIT OUR WEB SITE AT AFLAC.COM. For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- * hospitalization
- * physician services
- * hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- * other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- * Check the coverage in **all** health insurance policies you already have.
- * For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- * For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).



SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY (A71000 Series)

Supplemental Health Insurance Coverage
Application to: American Family Life Assurance Company of Columbus (Aflac)

Worldwide Headquarters • Columbus, Georgia 31999

New
Conversion

Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured					
Proposed Insured's Name		<u> </u>	 	NAI	
	Last	Fir		MI	
DOBMonth/Day/Year					
State of Birth:	Are you applyii If yes, Dependent Chi	ng for Dependent (Idren must be und	Child(ren) coverage? er age 25 at the time	☐Yes ☐No of application.	
Write spouse's name below if you have no spouse or yo	if you are applying for 1 w	o-Parent Family (or Named Insured/S	pouse Only coverage;	
Spouse's Name Last					
Last	First	MI	Month/Day/	Year	
AddressStreet or Post	. 0				
				Apt. No.	
City		State	ZIP		
Home Telephone ()					
Name of Employer/Associatio				(0.15.21)	
le this incurance intended to r	onlose any other health incu	uranga naw in fara	.2	(Optional) ☐ Yes ☐ No	
Is this insurance intended to real figures, please read and sign the					
Does anyone to be covered ha	ave any other Specified Hea	alth Event coverage	е		
with Aflac? If yes, this must be a conversi	on of that coverage. If was	aive current policy	v number and see Ite	☐ Yes ☐ No	
Policy Number:	-			111 20.	
Does anyone to be covered ha				☐ Yes ☐ No	
If yes, you may not apply for F Intensive Care policy is termin				ction at the and of this	
application and be aware that you cannot have Plan 2 of the Specified Health Event policy without canceling your existing Hospital Intensive Care policy with Aflac.					
	TO BE COMPLETED I	BY AFLAC ASSO	CIATE/AGENT		
Check Coverage ☐ Indivi Desired:	dual Named Insured Spouse Only	d/	rent Family	☐ Two-Parent Family	
☐ Plan 1: Specified Health Ev			/-		
 □ Plan 2: Specified Health Event with Hospital Intensive Care Unit Benefits (Policy Series A71200) □ First Occurrence Building Benefit Rider (Rider Series A71050) (\$500) 					
☐ Primary Specified Health Event Recovery Rider (Rider Series A71050)					
Billing Method:	•	Modes:			
☐ Direct	☐ Emp. Nonpayroll/Asso	oc. 🚨 01 Mon	thly (B/D & C/C Only)		
☐ Bank Draft (B/D, ACH)☐ List Bill	☐ Credit Card (C/C)	☐ 03 Qua	rterly	☐ 12 Annual	
Card Name					
Card No.					

VISA Prem	authorize American Family Life Assurance Company of Columbus (Aflac) to /MASTERCARD/AMERICAN EXPRESS account in accordance with the premium rate that niums will be advanced by my bank until I cancel authorization in writing to Aflac. Cancellation will be day of the month following Aflac's receipt of notice to cancel.	charge my I have chosen. e effective on the
	ature Date ciate's/Agent's No Sit. Code Billable Premium \$ Premium Collec	ted \$
7330	Oit. Code Diliable i Territarii \$ i Territarii Collec	,ιεα ψ
	PLEASE COMPLETE QUESTIONS 1 THROUGH 10 IF APPLYING FOR PLAN 1 OR PLAN	l 2.
1.	Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for any of the following?	□ Yes □ No
	Any disease, disorder, or abnormality of the heart including, but not limited to, cardiomyopathy, Heart Attack, congestive heart failure, or congenital heart disease (excluding surgically corrected atrial septal defect) Any disease, disorder or abnormality of the circulatory system, including, but not limited to, stroke, TIA, arterial blockage, or cerebral vascular insufficiency Chronic obstructive pulmonary disease (COPD) Cystic fibrosis Type I diabetes Impaired kidney function Kidney disease or disorder (excluding stones or acute infection) or kidney failure Liver disease or disorder (excluding hepatitis A) Systemic lupus Sickle cell anemia	
2.	Has anyone to be covered ever been diagnosed with or received medical treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)?	□ Yes □ No
3.	Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant?	□ Yes □ No
4.	Has anyone to be covered ever been diagnosed with or medically treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)?	□ Yes □ No
5.	Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer?	□ Yes □ No
6.	Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession?	☐ Yes ☐ No
7.	Within the last 12 months, has anyone to be covered received medical treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings?	□ Yes □ No
8.	Within the last six months, has anyone to be covered had or received treatment by a member of the medical profession for chest pain, shortness of breath, blackouts, fainting, or dizziness, or been advised by a member of the medical profession to have diagnostic tests to evaluate these symptoms?	□ Yes □ No

9.	If any one of Questions 1 through 8 is answered yes, was it the:						
	☐ Proposed Insured? ☐ Spouse? ☐ Child? If child, please list the name of the child(ren).						
lf th	Any person(s) so designated will not be covered under the policy. If the person named is the Proposed Insured named on the front of this application, a policy will not be issued.						
10.	Please list your height and weight: Height: ft. in. Weight: lbs.						
	Additional underwriting may be required.						
	PLEASE ONLY COMPLETE QUESTIONS 11 THROUGH 19 IF APPLYING FOR PLAN 2, POLICY SERIES A71200.						
11.	Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.	☐ Yes ☐ No					
	PLEASE INITIAL: Proposed Insured						
12.	Proposed Insured Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician?	□ Yes □ No					
13.	Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease?	□ Yes □ No					
14.	Has anyone to be covered ever been diagnosed with or medically treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea?	□ Yes □ No					
15.	In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery?	□ Yes □ No					
16.	Has anyone to be covered been hospitalized three or more times in the last two years?						
17.	In the last 12 months, has anyone to be covered received treatment in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit (not including treatment as a result of an accident)?	□ Yes □ No					
18.	In the last 12 months, has anyone to be covered been prescribed or taken any medication for the treatment of infertility?	□ Yes □ No					
19.	If any one of Questions 12 through 18 is answered yes, was it the:						
	☐ Proposed Insured? ☐ Spouse? ☐ Child? If child, please list the name of the child(ren).					
		_					

APPLICANT'S STATEMENTS AND AGREEMENTS:

- 20. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
- 21. I understand that the policy I am applying for will not cover any person who has attained age 65 before the Effective Date of the policy. The Intensive Care Benefits A, B, and J of the Plan 2 policy (Series A71200) reduce to half at age 70.
- 22. I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.
- 23. I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
- 24. I acknowledge receipt of, if applicable:

 □ Replacement Notice
 □ Guide to Health Insurance for People with Medicare
 □ Outline of Coverage
- 25. I understand that the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application and that: (a) Aflac is not bound by any statement made by me, the Proposed Insured or any associate/agent of Aflac unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- 26. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 1 through 8 or 12 through 18 is answered yes, the policy for which this application is made for the person(s) identified in Item 9 or Item 19 will be void, and coverage will continue for this person under the terms of the previous policy, if such policy remains in force. (b) The Time Limit on Certain Defenses provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy. (c) The Pre-Existing Conditions provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-Existing Conditions provision in the new policy will run from the new policy's Effective Date.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

	SUPPLEMENTAL NOTIFICATION				
COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC HOSPITAL INTENSIVE CARE COVERAGE.					
l,		cified Health Event Policy (Plan 2), which			
		are benefits under Aflac's Hospital Intensive			
	I understand that I must car	ncel existing Aflac Hospital Intensive Care			
coverage to purchase this Specific					
	ntensive Care Policy Number	I understand that I will be			
		e policy that may not be provided for in the			
new Specified Health Event	policy.				

I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the Aflac policy. I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated at	on
City and State	Date
Proposed Insured's Signature	
Associate's/Agent's Signature	Date
	nt Associate/Agent
AMERICAN FAMILY LIFE ASSURANCE COMPANY ADMINIS	ne following – it will become part of the policy. OF COLUMBUS (AFLAC), CLIENT SERVICES AND STRATION, 1999 TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
Associate/Agent's Name	
Associate/Agent's Address	Telephone

If we at AFLAC fail to provide you with reasonable and adequate service, you should feel free to contact:

ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION

1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR

TOLL-FREE 1-800-852-5494.

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC. FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522). VISIT OUR WEB SITE AT AFLAC.COM. For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- * hospitalization
- * physician services
- * hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- * other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- * Check the coverage in **all** health insurance policies you already have.
- * For more information about Medicare and Medicare Supplement insurance, review the Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare, available from the insurance company.
- * For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

REQUEST FOR CHANGE/APPLICATION FOR REINSTATEMENT AND/OR ADDITIONS SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY ATTENTION: POLICYHOLDER SERVICES (PHS)

American Family Life Assurance Company of Columbus (Aflac)

Worldwide Headquarters • Columbus, Georgia 31999 For information, call toll-free 1-800-99-AFLAC (1-800-992-3522). Fax number: 1-800-448-8922

	□ FIE-lax □	i Ailei-lax
Please Print in Blace	ck Ink	
Name of Policyholder		
Last Name Fire	st Name MI	
SSN Dat	te of Birth	
Policy Type Po	olicy Number	
Associate's/Agent's Signature	Writing Number	
Licensed Resident Associat	te/Agent	
PLEASE MAKE THE FOLLOWING CH	IANGES TO MY POLICY	
□ ADDRESS CHANGE ONLY		
New Address of Policyholder		
Street	Apt.	No.
City State ZIP	Telephone No	
Former Address of Policyholder		
Street		No.
City State	ZIP	
TRANSFERS TO BAVES I BILLING ONLY		
□ TRANSFERS TO PAYROLL BILLING ONLY		
Transfer From		
Transfer To	Transfer To	
Employer Name	Account Nu	ımber
Department No Employee No		
Amount Remitted \$ M	onths	
Billing Name		
Last Name Firs	st Name MI	
Effective Date of Transfer		

☐ TRANSFERS TO DIRECT BILLING☐ Bill at Home☐ Bank Draft☐	ONLY Credit Card		
Transfer From:	<u></u>		
Direct Billing Mode (select one) ☐ Monthly (Bank Draft/Credit Card Only)	I Quarterly □ Semian	nual 🛚 Annual
Amount Remitted \$	Months		
Effective Date of Transfer			
NAME CHANGE ONLY			
Name Shown on PolicyLast Name	First Name	MI	Title
Change Name To			
Last Name	First Name	MI	Title
Reason:	☐ Death ☐ Request		
Payroll Billing Name		(if p	oolicy is on payroll)
Draftee Name		(if police	cy is on bank draft)
Effective Date of Change			
□ DELETIONS ONLY			
Person to be Deleted	First None	NAI.	Tido
Last Name	First Name	MI	Title
Sex: Male Female			
Relationship:	☐ Child		
Reason for Deletion	eath		
Date of Divorce/Death/Request			
New Policy Holder's/Contract Holder's Full N			
	Last Name First N	Name	MI
Sex:	n Date of New Policy Holder/Contra	act Holder	
Billing Name (only applicable if policy on pay	roll)		
Ziming riamo (am) applicació il policy on pay	Last Name	First Name	MI
New Coverage Desired ☐ Individual ☐ C	ne-Parent Family 🚨 Two-Parent	t Family 🚨 Named I	nsured/Spouse Only

	ADDITIONS OF	NLY – Complete	applicable (questions	listed be	low.		
		he mother of a clage is Plan 1, Pol			but as ye	t unborn?		☐ Yes ☐ No
		are not payable ddition. (Comp						
PLEASE	E INITIAL:							
		Policyholder						
covered If yes, pl	have a Specific ease complete	ered have any otled Health Event part the Supplemental to canceling the A	policy that co al Notification	ntains inter below and	nsive care I be aware	benefits with that you can	Aflac?	□ Yes □ No
	COMPLETE	IF YOU ARE REPI			XISTING	AFLAC COVER	AGE WHICH CON	ITAINS
existing Event po	or Specified He Aflac Intensive blicy. cancel: y Specified Hea	ealth Event Policy Care coverage	y Number or Specified Number	Health Ev	ent cove	I urage to be co	c's Specified Hea Number Inderstand that lovered under this	Ith Event Policy. I must cancel my s Specified Health
I unders	tand that I will	sive Care Policy be terminating be Specified Health	enefits provi	ded for in			lealth Event poli	cy that will not be
•	s) to be Added	•	, ,					
. 0.001.(0	o) 10 20 / 1000	Last Name		First N	ame		MI	Title
Sex:	■ Male	☐ Female						
Relation	ship: 🗖 Spot	use 🖵 Child						
Reason	for Addition:	■ Marriage	☐ Birth	☐ Req	uest			
Date of I	Marriage/Birth/F	Request						
	•	ntract Holder's F	ull Name					
140W 1 01	noy i lolder 5/00	Thract Floract 5 T		Name		First Name		MI
Sex:	■ Male	☐ Female	Birth Date of	New Polic	y Holder/	Contract Hold	er	
Billing N	ame (only appli	cable if policy on	payroll)			—		
				Last N		First N		MI
New Cov	verage Desired	Individual	One-Pare	nt Family	□ Two-I	Parent Family	Named Insu	red/Spouse Only

Form A71003ARR1

3	REINSTATEMENT OF OR ADDITIONS TO POLICY ONLY -	Complete applicable questions	isted below.		
ΛNIS	ANSWER QUESTIONS 1 THROUGH 11 FOR REINSTATEMENTS OR ADDITIONS ON PAYROLL SALES ONLY.				
			SALES ONLT.		
1.	Has anyone to be covered ever been diagnosed with or receive the following by a member of the medical profession?	☐ Yes ☐ No			
	(not including stones or acute infection) Cerebral vascular insufficiency Congenital heart disease (excluding surgically corrected atrial septal defect)	Cardiomyopathy Stroke or TIA (two or more) Liver disease or disorder (excluding Hepatitis A) Cystic fibrosis Systemic lupus			
2.	Has anyone to be covered ever been diagnosed with or remember of the medical profession for diabetes (1) requiring five years, or (2) with complications to include retinopathy, neu (3) with continued tobacco use, or (4) diagnosed prior to age 3	the use of insulin within the last uropathy, or nephropathy, or	☐ Yes ☐ No		
3.	Has anyone to be covered ever had or been advised to have consulted with or been evaluated by a member of the medical Major Organ Transplant?		□ Yes □ No		
4.	Has anyone to be covered ever been diagnosed with or medic deficiency syndrome (AIDS) by a member of the medical p covered tested positive for human immunodeficiency virus (HIV)	□ Yes □ No			
5.	In the last five years, has anyone to be covered been diag treatment for any of the following by a member of the medical		☐ Yes ☐ No		
	Stroke or TIA (single event) Coronary artery disease	Atrial fibrillation Arterial blockage Heart Attack (single event) Peripheral vascular disease			
6.	Within the last two years, has anyone to be covered receive member of the medical profession for any medical cond treatment for cancer?		□ Yes □ No		
7.	Within the last 12 months, has anyone to be covered been put with blood thinners, not including aspirin, by a member of the r		□ Yes □ No		
8.	Within the last 12 months, has anyone to be covered received of the medical profession in an emergency room or hosp pressure (not related to pregnancy), or had a medication characteristic or the contraction of the medical profession in an emergency of the medical profession in an emergency of the medical profession of the medical profession in an emergency of the medical profession in the medical profes	ital for hypertension/high blood			
9.	readings? Within the last 12 months, has anyone to be covered been proheartbeat, heart palpitation, or tachycardia (not including previous to dental appointment), or has anyone to be covered.	ventive treatment with antibiotics dever required treatment by a	☐ Yes ☐ No		
10.	member of the medical profession with a pacemaker or defibril Within the last six months, has anyone to be covered had or b medical profession of the need to have diagnostic tests perfechest pain, shortness of breath, blackouts, fainting, or dizzines	een advised by a member of the formed to evaluate symptoms of	☐ Yes ☐ No ☐ Yes ☐ No		
11.	If any one of Questions 1 through 10 is answered yes, was	s it the:			
	☐ Proposed Insured/Employee? ☐ Spouse? ☐ Child?	If child, please list the name of t	he child(ren)		
-	Any person(s) so designated will not be co	overed under the policy.	·		

Form A71003ARR1 4 of 7

If the person named is the Proposed Insured/Employee named on the front of this application, a policy will not be issued.

PLEASE COMPLETE QUESTIONS 12 THROUGH 18 ONLY IF YOU ARE REINSTATING OR MAKING ADDITIONS TO PLAN 2, POLICY SERIES A71200.

12.	12. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? Please note, children born within 10 months of the reinstatement Effective Date of this policy will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.		
	PLEASE INITIAL:		
	Policyholder		
13.	Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician?	□ Yes □ No	
14.	Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease, or sickle cell anemia?	□ Yes □ No	
15.	Has anyone to be covered ever been diagnosed with or medically treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea?	☐ Yes ☐ No	
16.			
17.	In the last 12 months, has anyone to be covered received treatment for more than 24 hours in a Hospital Intensive Care Unit (not including treatment as a result of an accident)?		
18.	If any one of Questions 13 through 17 is answered yes, was it the:		
18.	If any one of Questions 13 through 17 is answered yes, was it the: ☐ Proposed Insured/Employee? ☐ Spouse? ☐ Child? If child, please list the name of the content of the c	he child(ren)	
_	• • •		
_	□ Proposed Insured/Employee? □ Spouse? □ Child? If child, please list the name of the person (s) so designated will not be covered under the policy. If the person named is the Proposed Insured/Employee named on the front of this application.	n, a policy	
_	□ Proposed Insured/Employee? □ Spouse? □ Child? If child, please list the name of the proposed Insured/Employee named on the front of this application will not be issued. COMPLETE NUMBERS 1 THROUGH 10 FOR ADDITIONS AND REINSTATEMENTS	n, a policy	

۷.	member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)?				
3.	Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant?				
4.	Has anyone to be covered ever been diagnosed with or medically treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)?	☐ Yes ☐ No			
5.	Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer?	☐ Yes ☐ No			
6.	Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession?	□ Yes □ No			
7.	Within the last 12 months, has anyone to be covered received medical treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings?	☐ Yes ☐ No			
8.	Within the last six months, has anyone to be covered had or received treatment by a member of the medical profession for chest pain, shortness of breath, blackouts, fainting, or dizziness, or been advised by a member of the medical profession to have diagnostic tests to evaluate these symptoms?	□ Yes □ No			
9.	If any one of Questions 1 through 8 is answered yes, was it the:				
	☐ Proposed Insured? ☐ Spouse? ☐ Child? If child, please list the name of the child	(ren).			
Any person(s) so designated will not be covered under the policy. If the person named is the Proposed Insured named on the front of this application, a policy will not be issued.					
10.	Please list your height and weight: Height: <u>ft. in.</u> Weight: <u>lbs.</u>				
Additional underwriting may be required.					
PLEASE COMPLETE QUESTIONS 11 THROUGH 19 ONLY IF YOU ARE REINSTATING OR MAKING ADDITIONS TO PLAN 2, POLICY SERIES A71200.					
11.	Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? Please note, children born within 10 months of the reinstatement Effective Date of this policy will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.	☐ Yes ☐ No			
	PLEASE INITIAL:				
12.	Policyholder Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician?	□ Yes □ No			
13.	Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease?	□ Yes □ No			

14.	medical prof	ession for emphysema, or has a	sed with or medically treated by a member nyone to be covered required the use of c excluding the use of a CPAP machine f	oxygen
15		• •	ad been diagnosed with or treated by a more	
13.	15. In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery?			
16.	Has anyone	to be covered been hospitalized the	three or more times in the last two years?	☐ Yes ☐ No
17.			vered received treatment in a Hospital Int Init (not including treatment as a result	
18.		2 months, has anyone to be cove t of infertility?	ered been prescribed or taken any medicat	ion for ☐ Yes ☐ No
19.	If any one o	f Questions 12 through 18 is an	swered yes, was it the:	
	☐ Proposed	Insured? Spouse? Child	d? If child, please list the name of	the child(ren).
	•	·	·	
				·
If the	e person nam		ted will not be covered under the policy. med on the front of this application, a po	
Event	or hospitaliza		loss resulting from a covered Primary or Se ys after the date of reinstatement. I under lth Event policy.	
statem deeme covera immed in con set for	nents and ansed represental age under the diately before nection with the the in my policy	swers provided herein, and they a tions and not warranties. I realize e policy. I understand that Afla the due date of the defaulted pren he reinstatement. I further underst y's Reinstatement Provision.	application, and I realize that policy reins are complete and true. All statements maze that any material misrepresentation the ac and I will have the same rights as p mium, subject to any provisions endorsed or tand that coverage under the reinstated pol	de in this application are rein may result in loss of rovided under the policy n or attached to the policy icy is subject to the terms
			lent claim for payment of a loss or benefit o lty of a crime and may be subject to fines a	
Signat	ture			
Signe	d and Dated a	ıt	on	
_		city :	and State	Date
	If we at Af	ARKANSAS INSURANCE DEPA 1200 W LITTLE ROCI	nable and adequate service, you should feel ARTMENT - CONSUMER SERVICES DIVIS VEST THIRD STREET K, ARKANSAS 72201-1904 1-2640 or Toll-Free 1-800-852-5494	
		FOR INFORMATION, CALL TO	CKS PAYABLE TO AFLAC. DLL-FREE 1-800-99-AFLAC (1-800-992-35 NEB SITE AT AFLAC.COM.	22).
	Γ	EOD WODI DWI	IDE HEADQUARTERS USE ONLY	
		TOR WORLDWI	DE HEADQUARTERO COL CRET	
		PTD	No. Months Dropped \$ Applied	
			No. Months Dropped \$ Applied No. Months	_

Form A71003ARR1 7 of 7

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC) Worldwide Headquarters • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999 TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

SPECIFIED HEALTH EVENT INSURANCE POLICY

Supplemental Health Insurance Coverage

Outline of Coverage for Policy Form Series A71100 THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.

- (1) Read Your Policy Carefully: This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.
- (2) Specified Health Event Insurance Coverage is designed to supplement your existing accident and Sickness coverage only when certain losses occur as a result of Specified Health Events. Primary Specified Health Events are: Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Major Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis, or Sudden Cardiac Arrest occurring after the Effective Date of coverage. Secondary Specified Health Events are: Coronary Angioplasty, with or without stents, occurring after the Effective Date of coverage. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by the provisions in Part (5).

Form A92397

- (3) Benefits: Subject to the Pre-existing Conditions provision, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered Specified Health Event that occurs while coverage is in force.
 - A. FIRST-OCCURRENCE BENEFIT: Aflac will pay the following benefit amount for each covered person when he or she is first diagnosed as having had a Primary Specified Health Event:

Named Insured/Spouse

\$5,000 (Lifetime maximum \$5,000 per covered person)

Dependent Children

\$7,500 (Lifetime maximum \$7,500 per covered person)

This benefit is payable only once for each covered person and will be paid in addition to any other benefit in the policy.

B. REOCCURRENCE BENEFIT: If benefits have been paid to a covered person under A above, Aflac will pay \$2,500 (two thousand five hundred dollars) if such covered person is later diagnosed as having had a subsequent Primary Specified Health Event.

For Benefit B to be payable, the Primary Specified Health Event must occur more than 180 days after the date Benefit A or Benefit B became payable. No lifetime maximum.

C. HOSPITAL CONFINEMENT BENEFIT (includes confinement in a U.S. government Hospital): When a covered person requires Hospital Confinement for the treatment of a covered Primary Specified Health Event, Aflac will pay \$300 (three hundred dollars) per day for each day a covered person is charged as an inpatient. This benefit is limited to confinements for the treatment of a covered Primary Specified Health Event that occur within 500 days following the occurrence of the most recent covered Primary Specified Health Event. No lifetime maximum.

Hospital Confinement Benefits are payable for only one covered Primary Specified Health Event at a time per covered person. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

Benefits are not payable on the same day as the Continuing Care Benefit (D). If the Hospital Confinement Benefit (C) and the Continuing Care Benefit (D) are payable on the same day, only the highest eligible benefit will be paid.

Benefits D through G will be paid for care received within 180 days following the occurrence of a covered Primary Specified Health Event. Benefits are payable for only one covered Primary Specified Health Event at a time per covered person. If a covered person is eligible to receive benefits for more than one covered Primary Specified Health Event, we will pay benefits only for care received within the 180 days following the occurrence of the most recent event.

- **D. CONTINUING CARE BENEFIT:** If, as the result of a covered Primary Specified Health Event, a covered person receives any of the following treatments from a licensed Physician, Aflac will pay \$125 (one hundred twenty-five dollars) each day a covered person is charged:
 - rehabilitation therapy
 physical therapy
 - 3. speech therapy
 - occupational therapy
 respiratory therapy
 - 6. dietary therapy/consultation
- 7. home health care
- 8. dialysis
- 9. hospice care
- 10. extended care
- 11. Physician visits
- 12. nursing home care

Treatment is limited to 75 days for continuing care commencing within 180 days following the occurrence of the most recent covered Primary Specified Health Event. Daily maximum for this benefit is \$125 (one hundred twenty-five dollars) regardless of the number of treatments received.

Form A92397

Benefits are not payable on the same day as the Hospital Confinement Benefit (C). If the Hospital Confinement Benefit (C) and the Continuing Care Benefit (D) are payable on the same day, only the highest eligible benefit will be paid. No lifetime maximum.

- **E. AMBULANCE BENEFIT:** If, due to a covered Primary Specified Health Event, a covered person requires ground ambulance transportation to or from a Hospital, Aflac will pay \$250 (two hundred fifty dollars). If air ambulance transportation is required due to a covered Primary Specified Health Event, we will pay \$2,000 (two thousand dollars). A licensed professional or licensed volunteer ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a Primary Specified Health Event. **Ambulance Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event.** No lifetime maximum.
- F. TRANSPORTATION BENEFIT: If a covered person requires special medical treatment that has been prescribed by the local attending Physician for a covered Primary Specified Health Event, Aflac will pay 50 cents (fifty cents) per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train, or bus fare) for transportation of a covered person for the round-trip distance between the Hospital or medical facility and the residence of the covered person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. Reimbursement will be made only for the method of transportation actually taken. This benefit will be paid only for the covered person for whom the special treatment is prescribed. If the special treatment is for a Dependent Child and commercial travel is necessary, we will pay this benefit for up to two adults to accompany the Dependent Child. The benefit amount payable is limited to \$1,500 (one thousand five hundred dollars) per occurrence of a covered Primary Specified Health Event. Transportation Benefits are not

payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event. THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON. No lifetime maximum.

- G. LODGING BENEFIT: Aflac will pay the charges incurred up to \$75 (seventy-five dollars) per day for lodging for you or any one adult family member when a covered person receives special medical treatment for a covered Primary Specified Health Event at a Hospital or medical facility. The Hospital, medical facility, and lodging must be more than 50 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 15 days per occurrence of a covered Primary Specified Health Event. Lodging Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event. No lifetime maximum.
- H. SECONDARY SPECIFIED HEALTH EVENT BENEFIT: Aflac will pay \$250 (two hundred fifty dollars) for each covered person under the policy when he or she has a Coronary Angioplasty, with or without stents. This benefit is limited to one Coronary Angioplasty per 30-day period. No lifetime maximum.

I. WAIVER OF PREMIUM BENEFIT:

Employed: If you, due to a Primary Specified Health Event (as defined in Part 1, Item R of the policy), are completely unable to do all of the usual and customary duties of your occupation for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement and a Physician's statement of your inability to perform said duties, and may each month thereafter require a Physician's statement that total inability continues.

Not Employed: If you, due to a Primary Specified Health Event (as defined in Part 1, Item R of the policy), are completely unable to perform three or more of the Activities of Daily Living (ADLs) without the assistance of another person for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require a Physician's statement of your inability to perform said activities, and may each month thereafter require a Physician's statement that total inability continues.

If you die and your spouse becomes the new Named Insured, premiums will start again and be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

While this benefit is being paid, Aflac may ask for and use an independent consultant to determine whether you can perform an ADL.

- J. CONTINUATION OF COVERAGE BENEFIT: Aflac will waive all monthly premiums due for the policy and riders for two months if you meet all of the following conditions:
 - 1. Your policy has been in force for at least six months;
 - 2. We have received premiums for at least six consecutive months;
 - 3. Your premiums have been paid through payroll deduction;
 - 4. You or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and
 - 5. You re-establish premium payments through:
 - a. your new employer's payroll deduction process, or
 - b. direct payment to Aflac.

You will again become eligible to receive this benefit after:

- 1. You re-establish your premium payments through payroll deduction for a period of at least six months, and
- 2. We receive premiums for at least six consecutive months.

"Payroll deduction" means your premium is remitted to Aflac for you by your employer through a payroll deduction process.

(4) Optional Benefits:

FIRST-OCCURRENCE BUILDING BENEFIT RIDER: (Series A71050) Applied for \square Yes \square No

The First-Occurrence Building Benefit as defined in the policy, will be increased by \$500 (five hundred dollars) on each rider anniversary date while this rider remains in force. (The amount of the monthly increase will be determined on a pro rata basis.) This benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each covered person on the anniversary date of this rider following the covered person's 65th birthday or at the time of a Primary Specified Health Event, subject to Part 2 of the policy, for that covered person, whichever occurs first. However, regardless of the age of the covered person on the Effective Date of this rider, this benefit will accrue for a period of at least five years unless a Primary Specified Health Event is diagnosed prior to the fifth year of coverage. (If this is Individual coverage, no further premium will be billed for this rider after the payment of benefits.)

PRIMARY SPECIFIED HEALTH EVENT RECOVERY BENEFIT RIDER: (Series A71051) Applied for □ Yes □ No

A covered person will be considered in Specified Health Event Recovery if he or she continues to be under the active care and treatment by a Physician for a covered Primary Specified Health Event OR if he or she is unable to engage in the duties of his or her regular occupation due to a covered Primary Specified Health Event. "Primary Specified Health Event" includes Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Major Third-Degree Burns, Persistent Vegetative State, Coma, or Paralysis occurring after the Effective Date of this rider.

Aflac will pay \$500 per month while a covered person remains in Primary Specified Health Event Recovery upon receipt of written proof of loss from that person's Physician.

For Periods of Primary Specified Health Event Recovery less than one month, we will pay a pro rata benefit. Lifetime maximum of six months per covered person.

PRE-EXISTING CONDITIONS: Benefits for a Primary Specified Health Event that is caused by a Pre-existing Condition will not be covered unless the Primary Specified Health Event occurs more than 30 days after the Effective Date of the rider.

LIMITATIONS AND EXCLUSIONS FOR RIDER SERIES A71051 ONLY:

A. Benefits for a Primary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Primary Specified Health Event at a time per covered person.

B. This rider does not cover losses or confinements caused by or resulting from:

1. Any loss sustained or contracted due, directly or indirectly, to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the Injury or cause of the loss occurred).

- 2. Participating in any sport or sporting activity for wage, compensation, or profit.
- 3. Intentionally self-inflicting bodily Injury or attempting suicide.
- 4. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

(5) Exceptions, Reductions and Limitations of the Policy (This is not a daily hospital expense plan.):

A. Benefits for a Primary or Secondary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary or Secondary Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Primary or Secondary Specified Health Event at a time per covered person.

B. The policy does not cover losses or confinements caused by or resulting from:

- 1. Any loss sustained or contracted due, directly or indirectly, to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the Injury or cause of the loss occurred).
- 2. Participating in any sport or sporting activity for wage, compensation, or profit.
- 3. Intentionally self-inflicting bodily Injury or attempting suicide.
- 4. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

A "Pre-Existing Condition" is an illness, disease, disorder, or Injury for which, within the six-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received from a Physician. Benefits for a Primary or Secondary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary or Secondary Specified Health Event occurs more than 30 days after the Effective Date.

(6) Renewability: The policy is guaranteed-renewable for life by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE
GOVERNING CONTRACTUAL PROVISIONS.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC) Worldwide Headquarters • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999 TOLL-FREE 1.800.99.AFLAC (1.800.992.3522)

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

SPECIFIED HEALTH EVENT INSURANCE POLICY Supplemental Health Insurance Coverage

Outline of Coverage for Policy Form Series A71200 THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.

- (1) Read Your Policy Carefully: This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.
- (2) Specified Health Event Insurance Coverage is designed to supplement your existing accident and Sickness coverage only when certain losses occur as a result of Specified Health Events. Primary Specified Health Events are: Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Major Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis, or Sudden Cardiac Arrest occurring after the Effective Date of coverage. Secondary Specified Health Events are: Coronary Angioplasty, with or without stents, occurring after the Effective Date of coverage. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by the provisions in Part (5).

Form A92398

(3) Benefits: Subject to the Pre-existing Conditions provision, if applicable, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered Specified Health Event that occurs while coverage is in force.

IMPORTANT: BENEFITS A, B, and J REDUCE BY ONE-HALF FOR LOSSES INCURRED ON OR AFTER THE POLICY ANNIVERSARY DATE FOLLOWING THE 70TH BIRTHDAY OF A COVERED PERSON.

Subject to Part 2, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits to a covered person, as applicable:

BENEFITS FOR HOSPITAL INTENSIVE CARE UNIT CONFINEMENTS:

- **A. HOSPITAL INTENSIVE CARE UNIT BENEFIT:** Aflac will pay the following benefits when a covered person incurs a charge for confinement in a Hospital Intensive Care Unit or a Step-Down Intensive Care Unit for a covered Sickness or Injury:
 - 1. Confinement in a Hospital Intensive Care Unit:

<u>Sickness</u>	<u>Injury</u>	<u>Days</u>
\$ 700 per day	\$ 800 per day	1–7
\$1,200 per day	\$1,300 per day	8–15

2. Confinement in a Step-Down Intensive Care Unit Benefit:

<u>Sickness</u>	<u>Injury</u>	<u>Days</u>
\$350 per day	\$350 per day	1–15

IMPORTANT: Benefits A1 and A2 are each limited to 15 days per Period of Confinement. Benefit A2 is also payable for confinement in a Hospital Intensive Care Unit after exhaustion of benefits payable under A1 above. No lifetime maximum.

IMPORTANT: Benefits payable under A1 or A2 above are not payable on the same day. If a covered person is charged for both on the same day, only the highest eligible benefit will be paid. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable. No lifetime maximum.

B. PROGRESSIVE BENEFIT FOR HOSPITAL INTENSIVE CARE UNIT/STEP-DOWN CARE UNIT CONFINEMENT: Two dollars indemnity will accumulate for the Named Insured and the covered spouse for each calendar month the policy remains in force after the Effective Date. This accumulated indemnity, if any, will be paid in addition to the Hospital Intensive Care Unit Benefit A1 and A2 for each day of Hospital Intensive Care Unit confinement for which benefits under A1 or A2 are payable. This Progressive Benefit will cease to build on the policy anniversary date following the 65th birthday of a covered person. Any amount accrued at the time this benefit ceases to build for a covered person will continue to be added to the benefit amount for all Hospital Intensive Care Unit/Step-Down Hospital Intensive Care Unit confinements commencing prior to the policy anniversary date following the 70th birthday of the covered person. THIS ACCUMULATED BENEFIT REDUCES AT AGE 70. This accumulated benefit will be reduced by one-half for Hospital Intensive Care Unit/Step-Down Intensive Care Unit confinements commencing on or after the policy anniversary date following the 70th birthday of a covered person. This benefit is not applicable and will not accrue to any covered person who has attained age 65 prior to the Effective Date of the policy. The Named Insured and covered spouse, if any, are the only persons eligible for this benefit if One-Parent Family or Two-Parent Family coverage is in force. Dependent Children do not qualify for this benefit. When a spouse is added to an existing policy, this benefit will begin to accrue from the endorsement date adding such spouse, provided the spouse has not yet attained age 65.

BENEFITS FOR PRIMARY SPECIFIED HEALTH EVENTS:

Subject to the Pre-Existing Conditions provision, Limitations and Exclusions, and all other policy provisions, Benefits F through H will be paid for care received within 180 days following the occurrence of a covered Primary Specified Health Event. Benefits are payable for only one covered Primary Specified Health Event at a time per covered person. If a covered person is eligible to receive benefits for more than one covered Primary Specified Health Event, we will pay benefits only for care received within the 180 days following the occurrence of the most recent event.

C. FIRST-OCCURRENCE BENEFIT: Aflac will pay the following benefit amount for each covered person when he or she is first diagnosed as having had a Primary Specified Health Event:

Named Insured/Spouse

\$5,000 (Lifetime maximum \$5,000 per covered person)

Dependent Children

\$7,500 (Lifetime maximum \$7,500 per covered person)

This benefit is payable only once for each covered person and will be paid in addition to any other benefit in the policy.

D. REOCCURRENCE BENEFIT: If benefits have been paid to a covered person under C above, Aflac will pay \$2,500 (two thousand five hundred dollars) if such covered person is later diagnosed as having had a subsequent Primary Specified Health Event.

For Benefit D to be payable, the Primary Specified Health Event must occur more than 180 days after the date Benefit C or Benefit D became payable. No lifetime maximum.

E. HOSPITAL CONFINEMENT BENEFIT (includes confinement in a U.S. government Hospital): When a covered person requires Hospital Confinement for the treatment of a covered Primary Specified Health Event, Aflac will pay \$300 (three hundred dollars) per day for each day a covered person is charged as an inpatient. This benefit is limited to confinements for the treatment of a covered Primary Specified Health Event that occur within 500 days following the occurrence of the most recent covered Primary Specified Health Event. No lifetime maximum.

Hospital Confinement Benefits are payable for only one covered Primary Specified Health Event at a time per covered person. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

- **F. CONTINUING CARE BENEFIT:** If, as the result of a covered Primary Specified Health Event, a covered person receives any of the following treatments from a licensed Physician, Aflac will pay \$125 (one hundred twenty-five dollars) each day a covered person is charged:
 - rehabilitation therapy
 home health care
 - physical therapy
 speech therapy
 occupational therapy
 respiratory therapy
 dialysis
 hospice care
 extended care
 respiratory therapy
 dietary therapy/consultation
 nursing home care

Treatment is limited to 75 days for continuing care commencing within 180 days following the occurrence of the most recent covered Primary Specified Health Event. Daily maximum for this benefit is \$125 (one hundred twenty-five dollars) regardless of the number of treatments received.

Form A92398

Benefits are not payable on the same day as the Hospital Confinement Benefit (E). If the Hospital Confinement Benefit (E) and the Continuing Care Benefit (F) are payable on the same day, only the highest eligible benefit will be paid. No lifetime maximum.

- G. TRANSPORTATION BENEFIT: If a covered person requires special medical treatment that has been prescribed by the local attending Physician for a covered Primary Specified Health Event, Aflac will pay 50 cents (fifty cents) per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train, or bus fare) for transportation of a covered person for the round-trip distance between the Hospital or medical facility and the residence of the covered person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. Reimbursement will be made only for the method of transportation actually taken. This benefit will be paid only for the covered person for whom the special treatment is prescribed. If the special treatment is for a Dependent Child and commercial travel is necessary, we will pay this benefit for up to two adults to accompany the Dependent Child. The benefit amount payable is limited to \$1,500 (one thousand five hundred dollars) per occurrence of a covered Primary Specified Health Event. Transportation Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event. THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON. No lifetime maximum.
- H. LODGING BENEFIT: Aflac will pay the charges incurred up to \$75 (seventy-five dollars) per day for lodging for you or any one adult family member when a covered person receives special medical treatment for a covered Primary Specified Health Event at a Hospital or medical facility. The Hospital, medical facility, and lodging must be more than 50 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 15 days per occurrence of a

covered Primary Specified Health Event. Lodging Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event. No lifetime maximum.

BENEFIT FOR SECONDARY SPECIFIED HEALTH EVENTS:

Subject to the Pre-existing Conditions provision, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits to a covered person, as applicable:

I. SECONDARY SPECIFIED HEALTH EVENT BENEFIT: Aflac will pay \$250 (two hundred fifty dollars) for each covered person under the policy when he or she has a Coronary Angioplasty, with or without stents. This benefit is limited to one Coronary Angioplasty per 30-day period. No lifetime maximum.

MISCELLANEOUS BENEFITS:

Subject to the Pre-Existing Conditions provision, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits to a covered person, as applicable:

- J. MAJOR HUMAN ORGAN TRANSPLANT BENEFIT: Aflac will pay \$25,000 (twenty-five thousand dollars) as a result of a Major Human Organ Transplant procedure when a covered person is confined in a Hospital and receives one or more of the following human organs: kidney, liver, heart, lung, or pancreas. Transplant procedures involving more than one major organ will be considered to be one organ transplant procedure. This benefit is not payable for transplants involving mechanical or nonhuman organs and is limited to one procedure per 180-day period. No lifetime maximum.
- K. AMBULANCE BENEFIT: If, due to a covered Primary Specified Health Event or confinement in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit for a covered Sickness or Injury, a covered person requires ground ambulance transportation to or from a Hospital, Aflac will pay \$250 (two hundred fifty dollars). If air ambulance transportation is required due to a covered Primary Specified Health Event for a covered Sickness or Injury, or confinement in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit, we will pay \$2,000 (two thousand dollars). A licensed professional or licensed volunteer ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a Primary Specified Health Event or confinement in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit for a covered Sickness or Injury. Ambulance Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event. No lifetime maximum.

L. WAIVER OF PREMIUM BENEFIT:

Employed: If you, due to a Primary Specified Health Event (as defined in Part 1, Item T of the policy), are completely unable to do all of the usual and customary duties of your occupation for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement and a Physician's statement of your inability to perform said duties, and may each month thereafter require a Physician's statement that total inability continues.

Not Employed: If you, due to a Primary Specified Health Event (as defined in Part 1, Item T of the policy), are completely unable to perform three or more of the Activities of Daily Living (ADLs) without the assistance of another person for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require a Physician's statement of your inability to perform said activities, and may each month thereafter require a Physician's statement that total inability continues.

If you die and your spouse becomes the new Named Insured, premiums will start again and be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises. While this benefit is being paid, Aflac may ask for and use an independent consultant to determine whether you can perform an ADL.

- M. CONTINUATION OF COVERAGE BENEFIT: Aflac will waive all monthly premiums due for the policy and riders for two months if you meet all of the following conditions:
 - 1. Your policy has been in force for at least six months;
 - 2. We have received premiums for at least six consecutive months;
 - 3. Your premiums have been paid through payroll deduction;
 - 4. You or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and
 - 5. You re-establish premium payments through:
 - a. your new employer's payroll deduction process, or
 - b. direct payment to Aflac.

You will again become eligible to receive this benefit after:

- 1. You re-establish your premium payments through payroll deduction for a period of at least six months, and
- 2. We receive premiums for at least six consecutive months.

"Payroll deduction" means your premium is remitted to Aflac for you by your employer through a payroll deduction process.

(4) Optional Benefits:

FIRST-OCCURRENCE BUILDING BENEFIT RIDER: (Series A71050) Applied for ☐ Yes ☐ No

The First-Occurrence Building Benefit as defined in the policy, will be increased by \$500 (five hundred dollars) on each rider anniversary date while this rider remains in force. (The amount of the monthly increase will be determined on a pro rata basis.) This benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each covered person on the anniversary date of this rider following the covered person's 65th birthday or at the time of a Primary Specified Health Event, subject to Part 2 of the policy, for that covered person, whichever occurs first. However, regardless of the age of the covered person on the Effective Date of this rider, this benefit will accrue for a period of at least five years unless a Primary Specified Health Event is diagnosed prior to the fifth year of coverage. (If this is Individual coverage, no further premium will be billed for this rider after the payment of benefits.)

PRIMARY SPECIFIED HEALTH EVENT RECOVERY BENEFIT RIDER: (Series A71051) Applied for □ Yes □ No

A covered person will be considered in Specified Health Event Recovery if he or she continues to be under the active care and treatment by a Physician for a covered Primary Specified Health Event OR if he or she is unable to engage in the duties of his or her regular occupation due to a covered Primary Specified Health Event. "Primary Specified Health Event" includes Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Major Third-Degree Burns, Persistent Vegetative State, Coma, or Paralysis occurring after the Effective Date of this rider.

Aflac will pay \$500 per month while a covered person remains in Primary Specified Health Event Recovery upon receipt of written proof of loss from that person's Physician.

For Periods of Primary Specified Health Event Recovery less than one month, we will pay a pro rata benefit. Lifetime maximum of six months per covered person.

PRE-EXISTING CONDITIONS: Benefits for a Primary Specified Health Event that is caused by a Pre-existing Condition will not be covered unless the Primary Specified Health Event occurs more than 30 days after the Effective Date of the rider.

LIMITATIONS AND EXCLUSIONS FOR RIDER SERIES A71051 ONLY:

A. Benefits for a Primary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Primary Specified Health Event at a time per covered person.

B. This rider does not cover losses or confinements caused by or resulting from:

- 1. Any loss sustained or contracted due, directly or indirectly, to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the Injury or cause of the loss occurred).
- 2. Participating in any sport or sporting activity for wage, compensation, or profit.
- 3. Intentionally self-inflicting bodily Injury or attempting suicide.
- 4. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

(5) Exceptions, Reductions and Limitations of the Policy (This is not a daily hospital expense plan.):

- **A.** Benefits payable under Part 5, A, B, and J of the policy will be reduced by one-half for losses that begin on or after the policy anniversary date following the 70th birthday of a covered person.
- **B.** Benefits are not payable under Part 5, A1 and B, **Hospital Intensive Care Unit**, for confinement in units such as telemetry or surgical recovery rooms, postanesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency room or outpatient surgery units; or other facilities that do not meet the standards for a Hospital Intensive Care Unit. Benefits are not payable under Part 5, A2 and B, **Step-Down Intensive Care Unit**, for confinement in units such as telemetry or surgical recovery rooms, postanesthesia care units, beds, wards, or private or semiprivate room with or without telemetry monitoring equipment, observation units located in emergency room or outpatient surgery units, emergency rooms, labor or delivery rooms; or other facilities that do not meet the standards for a Step-Down Intensive Care Unit.

Form A91345

- **C.** Benefits are not payable for losses or confinements that begin or occur before the policy Effective Date or after termination of the policy.
- **D.** Benefits for a Primary or Secondary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary or Secondary Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Primary or Secondary Specified Health Event at a time per covered person.

E. The policy does not cover losses or confinements caused by or resulting from:

- 1. Participating in any sport or sporting activity for wage, compensation, or profit. This exclusion does not apply to Part 5, Benefits A, B, or J of the policy.
- 2. Intentionally self-inflicting bodily Injury or attempting suicide.

Form A71260AR

- 3. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.
- 4. Participating in or attempting to participate in any illegal activity that is classified as a felony, whether charged or not (the term "felony" is as defined by the law of the jurisdiction in which the activity takes place).
- 5. Having treatment for a mental or nervous disorder or disease.
- 6. Any loss sustained or contracted due, directly or indirectly, to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the Injury or cause of the loss occurred).

A "Pre-Existing Condition" is an illness, disease, disorder, or Injury for which, within the six-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received from a Physician. Benefits for a Primary or Secondary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary or Secondary Specified Health Event occurs more than 30 days after the Effective Date. The Pre-Existing Condition DOES NOT apply to any Hospital Intensive Care benefits under the policy.

(6) Renewability: The policy is guaranteed-renewable for life by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE
GOVERNING CONTRACTUAL PROVISIONS.







Rita S. Golden, HIA, AIRC, ACS, MHPDirector, Regulatory Compliance
Compliance Department

March 20, 2006

Ms. Rosalind Minor Arkansas Insurance Department 1200 West Third Street Little Rock, AR 72201-1904 RECEIVED

MAR 2 3 2006

LIFE AND HEALTH ARKANSAS INSURANCE DEPARTMENT

APPRILIPE AND HEALTH ARKANSAS INSURANCE DEPARTMENT

NAIC# 60380

Re: Specified Health Event Policy Forms A71100AR and A71200AR, First-Occurrence Building Benefit Rider A71050, Primary Specified Health Event Recovery Benefit Rider A71051AR, Payroll Application Forms A71001AR and A71001AAR, Non-payroll Application Forms A71002AR and A71002AAR, Request for Change/Application for Reinstatement And/Or Additions Form A71003AR, and Outline of Coverage Forms A71125AR and A71225AR.

Dear Ms. Minor:

Referenced forms are resubmitted for your review and approval. Per our phone conversation on March 17, 2006, our filing contains individual policies marketed to applicants on a nonpayroll and payroll basis. Although this product may be offered on a payroll or association basis, it is still an individual policy and a policy is issued to each individual applicant. These policies are not issued through a group, association or trust. There are no enrollees or a master policy.

I certify that the forms submitted herewith meet the applicable provisions of Rule and Regulation 18 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of the Arkansas Insurance Department.

This filing has been prepared by Connie Gates. Should you have any questions concerning this filing, please do not hesitate to contact her by calling collect at (706) 596-5048, by faxing her at (706) 660-7080 or by e-mailing her at cgates@aflac.com. A return envelope is enclosed for your convenience to reply.

Sincerely,

Rita S. Golden RG/CG/cg Enclosures

u Golden

SERFF Tracking Number: AFLA-126789903 State: Arkansas
Filing Company: American Family Life Assurance Company of State Tracking Number: 46768

Columbus

Company Tracking Number: A71000RAPPS

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness

Limited Benefit

Product Name: Payroll, Union and Non-payroll Specified Health Event Application Forms

Project Name/Number: A71000 applications/A71001RAR

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/10/2010	Form	Payroll/Union Application	09/24/2010	
09/10/2010	Form	Payroll/Union Application	09/24/2010	
09/10/2010	Form	Non-payroll Application	09/24/2010	
09/10/2010	Form	Non-payroll Application	09/24/2010	
09/10/2010	Form	Request for Change/Application for Reinstatement and/or Additions	09/24/2010	